

THE  
AMERICAN PRACTITIONER:

A MONTHLY JOURNAL OF  
MEDICINE AND SURGERY.

EDITED BY

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A MONTHLY JOURNAL OF

## MEDICINE AND SURGERY.


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# THE AMERICAN PRACTITIONER.

SEPTEMBER, 1873.

Certainly it is excellent discipline for an author to feel that he must say all he has to say in the fewest possible words, or his reader is sure to skip them; and in the plainest possible words, or his reader will certainly misunderstand them. Generally, also, a downright fact may be told in a plain way; and we want downright facts at present more than any thing else.—RUSKIN.

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## Original Communications.

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### A CASE OF GENERAL PARESIS.

BY J. B. STONEHOUSE, JR., M. D.,

*Assistant Physician Sanford Hall, Flushing, New York.*

Certain diseases—which indeed properly belong to the domain of the specialist, but are in the earlier stages, when a proper appreciation of the symptoms is of the greatest importance, in the hands of the general practitioner—are seldom spoken of in the text-books or by the college instructors, while the medical journals only at wide intervals refer to them. One of these, general paresis, is peculiarly liable to a mistaken diagnosis, with the consequent damage to the patient's chances of recovery: especially is this the case when the paresis precedes the development of the *psychical* symptoms. A recent writer (Guy's Hospital Reports, 1870) argues that cases occur outside of the hospitals for the insane which deserve the title of general paresis as fully as those within. In accordance with this view, and with the hope of presenting to the readers of the Practitioner in a small space a general

idea of the disease, with the views thereon of the recognized authorities, this article has been prepared. The case reported is one which was at no time in an asylum, and is therefore chosen for the text.

M. H., merchant, aged forty-three years, single, of good habits and of previous excellent health. The first symptoms observed by him, and for which he sought the advice of a physician, were a feeling of fullness of the head, with vertigo, an inability to perform any severe mental labor, and loss of memory. Two months later mental symptoms made their appearance. Patient declared he was not fitted for his business, and would ruin his partners. He said it had been decreed by Providence that he should fail if he continued in the business. After much deliberation he concluded to change his occupation, and selected the popular lecture-field for his future operations, expressing great faith in his oratorical powers, and displaying all that wonderful train of mental symptoms usual in the "*délire des grandeurs*." Even while making these assertions a peculiar trembling of the lips, "as if about to burst into tears" (Maudsley), often embarrassing his articulation very perceptibly, was noticed. This condition increased rapidly until he was unable to pronounce the *labials*. The right pupil was contracted;\* paresis of the muscles of deglutition and expression soon took place; the use of the fingers, and later of the lower extremities, became impaired. A failure of muscular power, with considerable spasmodic action after continued effort to grasp the instrument, was shown by the dynamometer. Muscles of the extremities responded to the electric stimulus. He was unable to dress himself without great effort. His gait at this time was very similar to that observed in cases of sclerosis of posterior

\* Hammond (Diseases of the Nervous System, page 369) quotes Austin (Pract. Acct. of General Paralysis, etc., London, 1859) as asserting that contraction of the right pupil is associated with melancholic delusions, and contraction of the left pupil with the more self-complacent fancies. This, however, can not be supported.



columns of the spinal cord. A spasmodic action of the pulse (which varied from 90 to 100 per minute) was exhibited by the sphygmograph. Ophthalmic examination was made only during the first stages of the disease, without revealing any lesions of the optic nerve. No convulsions, comatose attacks, or maniacal exacerbations occurred during the course of the disease. From the end of the third month his mental powers steadily diminished into a condition of dementia. Urine and fæces passed involuntarily, and the patient would remain in contact with them until the sense of smell informed him of his condition. At this time there was anæsthesia of the greater portion of the cutaneous surface and of the mucous membranes, as far as could be noticed. This condition was not complete in the axillary and inguinal regions. Extreme loss of memory was observable. He seldom remembered an extravagant idea longer than the time occupied in uttering it. When asked his own name, in the later periods, he could not answer. During a brief absence of the nurse from the room death occurred from impaction of food in the fauces, owing to anæsthesia of these parts. From the appearance of the first symptoms to the day of death was five months and fifteen days.

Among the points of interest noticed in this case are the following:

1. The short duration of so typical a case. Hammond gives the average duration as three years.
2. The absence of any definite cause. The patient, as we have before stated, was a man of excellent habits. He was an active and consistent temperance man. An inquiry as to his past history revealed the fact that several years before the attack, during which time he enjoyed very good health, the patient had been severely mercurialized during a course of treatment for some liver trouble. Could this have produced a condition of the nervous system inviting the development of the disease?

*Synonyms.* General paresis, general paralysis of the insane, paresifying mental disease, paresis generalis, insania paresans, dementia paralytica, anioia paralytica, geisteskrankheit mit paralysie, paralysie générale, aliénation ambitieuse avec paralysie incomplète, folie paralytique, délire des grandeurs.

As to the causation of general paralysis, no great certainty of opinion has been reached. Abuse of alcohol, the narcotics, etc., venereal excesses, and many other habits and conditions have been charged with the production of this disease. Many cases occur, however, which can not be traced to this class of causes. The disease is comparatively rare among women. France gives a much larger proportion of cases than any other nation. Saloman ascribes to the female cases the depressed form of mental symptoms. In general paresis no order of symptoms is a typical one. The mental or physical symptoms may appear first, or they may be simultaneous. Parchappe reports that in eighty-six cases fifty-one were marked by the simultaneous appearance of the mental symptoms and paresis; in twenty-seven cases the paresis was subsequent, and in eight the precedence could not be determined. Leidesdorf relates the history of a case in which the earliest symptoms were spinal. On this point Maudsley says: "Before asserting in a particular case that there is no evidence of paralysis, it will be well to observe the patient when emotionally excited, or after a sleepless night; then there may be exhibited a tremulousness about his speech which is not at all visible when he is perfectly calm and collected." Forbes Winslow (*Obscure Diseases of the Brain and Disorders of the Mind*) says, speaking of the peculiar mental symptoms of the disease: "I have known the tendency to distort facts and look extravagantly at the bright side of every thing through an intensely magnified and highly-colored, because morbid, medium to exist for five or even ten years before the mind presented any decided and recognized symptoms of alienation." M. Parchappe, in an address before the Medico-

Psychological Society of Paris, 1858, says: "Mental disorder is constant from the first, at least under the form of impairment of the memory and judgment, and very frequently under that of maniacal or melancholic excitement."

The testimony of these quotations shows how difficult is not only the decision of the precedence of the symptoms, but also the diagnosis of the disease. The mental symptoms are ushered in by a stage of melancholia; but even this bears on the exaggeration of the *ego*—the patient is boastful of bodily ailments or persecutions. Gradually the ideas become more of the *ambitieux* type; an exaggeration of all that is favorable in the man or his life, and a new and falsely-colored representation of what is unworthy. With continued loss of memory we find a diminution in the coherence of ideas, until in the later stages there is observed merely the utterance of disconnected egotisms and optimisms. Finally these psychical symptoms are not, according to some authorities, characteristic of the disease. M. Trélat (*Annales Médico-Psychologiques*, 1855) writes: "A great number of paralytics have no ideas of riches or greatness. There are some who, instead of being powerful, happy, and full of confidence, are timid, distrustful, and agitated by hypermaniacal ideas." M. Laséque (thesis on his examination for a fellowship, quoted by M. Arch Foville, jr., *Quarterly Journal of Psychological Medicine*, New York, April, 1872) says "the characteristic delirium may be wanting in spite of the intellectual disturbance." And again M. Linas (quoted by the same authority) declares "he could not raise his voice too energetically against the opinion which assigns to general paralysis a definite delirium."

Among the first physical symptoms calling for medical treatment may be apoplectiform or epileptiform attacks and signs of cerebral congestion. The difficulties of articulation are usually among the earlier symptoms. Articulation becomes thick and labored and loses distinctness and precision.

Especial difficulty is experienced in the pronunciation of the labials. In the last stages "it consists only in the muttering of thick, indistinctly-articulated noises." Saloman (translated by Moore and quoted by Delayé) accounts for this condition by the "transient convulsive movements (involuntary spasms) of the muscles of the face, especially of the upper lip," and "fibrillar convulsions in the muscles of the tongue." The pathology of this condition is the implication of the anterior lobes in the degeneration, whether such changes be considered, with Parchappe, a cerebral softening (Medico-Psychological Society of Paris, 1858), or Delayé, a molecular change of the cerebral tissue, especially of the gray substance (*De la paralysie générale incomplète, Thèse de Paris*, 1822), or Bayle, a meningitis (*Recherches sur les Maladies Mentales*, Paris, 1822), or Behomme (quoted by Parchappe), a meningo-cerebritis, or Calmeil, a chronic diffused peri-encephalo-meningitis (*De la paralysie considérée chez les Aliénés*, Paris, 1822).

It is of importance to remember that the condition of the limbs is not one of palsy, where the muscles refuse to respond to the mandate of the nervous centers; but, as the late Dr. Skae, of the Morningside Asylum of Scotland, states it (*Edinburgh Medical Journal*, April, 1860), "the volition is irregularly conveyed and distributed. The person can not control and direct his movements perfectly and consentaneously, just as a drunken man sees double because he can not converge upon a given object, or walks unsteadily because he can not direct and regulate the harmonious movements of his limbs." Dr. Reynolds, in his treatise on wasting palsy, states the means of diagnosis between general paresis and wasting palsy to be that in general paresis the muscles respond to the electrical stimulus, and in wasting palsy they do not. The functions of sight and hearing are not in ordinary cases involved except in the last stages. Smell and taste are much oftener affected, so that, according to Saloman, "the patient submits to their operation the most loathsome things." Hallu-

cinations (endogenous sensations) are not unfrequently met with in sight and hearing. Hyperæsthesia and anæsthesia of the skin and mucous membranes are occasional but not essential symptoms of the disease. M. Parchappe noticed a slight increase of the frequency of the pulse in general paresis, although the disease, except accidentally in the state of congestion, is not accompanied by a true febrile movement. In the last stage, a condition called by M. Parchappe "cerebral marasmus," in which occur pyæmia, pneumonia, colliquative diarrhea, gangrenous destruction of tissue from effects of pressure, terminates the sad history. All these symptoms are subject to ameliorations, which to the inexperienced lend false hopes of recovery.

The prognosis is always *unfavorable*. Parchappe says: "I have not obtained a single positive and certain cure." Dr. G. Mackenzie Bacon (Journal of Mental Science, London, July, 1871) declares: "Whatever the hopes of the therapeutics of the future, I can see no reason to wander through the pharmacopœia in search of a drug to cure a disease which depends essentially on structural changes, when we know that these, at least in the brain, are not remedied by medicines."

In the treatment of general paresis, tonics and stimulants are always of use, with sedatives or narcotics when necessary.

Parchappe, as a fair exponent of the French alienists, says of the pathology of the disease: "In the majority of cases the softening (which he considers the characteristic lesion) is found at the surface on the free margin of the convolutions. At a later period it often attacks the gray matter of the corpora striata, optic thalami, medulla spinalis, and cerebellum. Mental disorder, under the form of mania or melancholia, coincides with the superficial alteration of the cortical substance; the paresis and dementia is connected with the deeper alterations, the difficulty of speech with the lesion of the anterior lobes. A greater degree of softening is often found

on one side, then the paresis is more determined on the other." In America the only investigations of importance have been begun at the New York State Asylum, by its special pathologist, Dr. E. R. Hun, of Albany, N. Y. In his last report he speaks of the autopsies in cases of general paresis: "Of the eight cases of general paresis six were men and two women, the oldest sixty-four and the youngest thirty-three years of age. In five cases there were eschars or ill-conditioned ulcers observed upon the surface of the body; the skull-cap was unusually thick in four cases; the membranes were adherent to each other in four cases; the arachnoid opaque in four and congested in one; a considerable amount of sub-arachnoid serous effusion was noticed in seven of the eight cases, and in two cases clots of blood were found upon the surface of the brain. In six of the eight cases there was more or less atrophy of the cerebral convolutions, and in one case embolism of the middle cerebral artery was accompanied by softening of the hemispheres. In this case two small cysts filled with clear serous fluid were found encroaching upon the brain substance. The weight of the encephalic mass (including cerebrum, cerebellum, pons, and medulla) was taken in three cases; the heaviest weighed  $48\frac{1}{4}$  ounces and the lightest  $35\frac{1}{4}$  ounces, the average weight being  $43\frac{1}{3}$  ounces. In five of the cases there was existing tubercular disease, or evidences that such disease had formerly existed, as shown by cicatrices and cretaceous deposits in the lungs. In one case ossification of the mitral valve was found, and in three was marked deflection of the transverse colon toward the symphysis pubis."

FLUSHING, N. Y.



## CHANGES OF TEMPERATURE AND PULSE IN YELLOW FEVER.

BY JOSEPH JONES, M. D.,

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Owing perhaps chiefly to the sudden origin, rapid progress, and singularly fatal nature of yellow fever, as well as the infrequency of the use of the thermometer in the investigation of the disease, but few facts of value relating to the definite degrees of temperature in the different stages of the disease can be found in the writings of various observers. Almost all observers, however, as Benjamin Rush, J. Deveze, Wm. Currie, C. Caldwell, Samuel Jackson, P. Chas. A. Louis, W. Arnold, R. Jackson, Lionel Chalmers, John Lining, A. M. F. Savarésy, William T. Wragg, Daniel Blair, John Davy, Schmidtlein, and many others, concur in the statement that in the early stage of reaction or febrile excitement the temperature is elevated to a greater or less degree, in different cases, above the standard of health; and still further, that this elevation of temperature is not permanent, but at the end of from two to five days, in most cases, is succeeded by a decided fall; and, although the symptoms may be of the gravest character and the patient *in extremis*, neither the elevation of the temperature nor the frequency of the pulse give any true indication of the danger.

The general results of my investigations upon the changes of temperature and conditions of the pulse in yellow fever may be formulated thus:

The maximum elevation of temperature is attained upon the first, second, and third days of the disease; ranging, according to the severity of the attack, from 102° to 110° in the axilla; and, as a general rule, from the third to the



fifth day steadily falls and sinks down to the normal standard, and even below. In some fatal cases it rises again toward the end, rarely, however, reaching or exceeding, during the stage of passive hemorrhages, black vomit, jaundice, and urinary suppression,  $104^{\circ}$ ; and, as a general rule, never attains the high degree of temperature characteristic of the first stage. The supervention of an inflammatory disease, or the occurrence of an abscess, or the access of malarial fever, after the first stage, may in like manner cause a progressive elevation of temperature, with slight evening exacerbations.

The pulse at the commencement of the attack is rapid and full. The frequency of the pulse does not, however, as a general rule, continue to correspond with the elevation and oscillations of temperature, as in many other febrile diseases; and in many cases the remarkable phenomenon is witnessed of the pulse progressively decreasing in frequency, and even descending below the normal standard, while the temperature is maintained at an elevated degree; and on the other hand the pulse frequently increases in frequency, but diminishes in force, near the fatal issue. The occurrence of copious hemorrhage from the stomach or bowels may be attended with sudden depression of temperature, and increase in frequency but diminution in the force and fullness of the pulse.

The remarkable progressive decrease in the beats of the pulse after the first stage in many cases appears to be due to several causes; as the anatomical changes in the heart (acute fatty degeneration), and the retention in the blood of the bile and urinary constituents.

If the temperature rises in the first stage above  $105^{\circ}$ , the patient is in imminent danger; and if it reaches from  $107^{\circ}$  to  $110^{\circ}$ , death is inevitable, whatever may be the treatment adopted. In cases attended with the rapid rise of the temperature to  $106^{\circ}$  and beyond in the first stage, death sometimes occurs suddenly, and apparently solely from the effects upon the blood and nervous system of the great

elevation of temperature, as in sunstroke. The truth of this statement will best be illustrated by actual observations, and especially by the following case, which has recently occurred in my private practice.

Mrs. W., aged twenty-eight years, has resided in New Orleans eighteen months; large, well-developed, with clear complexion and high color in health. Mrs. W. called at my office July 21st, stating that she had just passed through the menstrual period, which had been protracted for ten days, was very profuse, and had confined her to bed. She complained of great weakness, "heaviness" of feeling, vertigo, and pain in the head, back, and limbs, symptoms which appeared to be attributable, at least in part, to the hemorrhage, as I had attended her upon previous occasions when analogous symptoms resulted from profuse menstruation.

July 22d, 1 P. M., I was called to Mrs. W., and found her suffering with slight febrile excitement; pulse 90, full and strong; face flushed; pain in head, back, and limbs.

July 23d, 9 A. M.—Face greatly flushed and of scarlet hue; capillaries of the extremities and face and surface generally congested; patient greatly agitated and alarmed; says she has yellow fever, and will surely die. It was difficult, if not impossible, to calm her fears. Skin warm, but bathed in profuse perspiration; pulse 108, full and strong; great pain in back and head. 3:30 P. M.: Pulse 110; temperature 103.5°; urine abundant, light-yellow, slightly turbid from presence of vesical and vaginal mucus; a trace of albumen. Menstrual flow returned for an hour or two during the morning, but ceased again; capillaries of the surface intensely congested; tongue red at tip and edges, furred in center.

July 24th, 9 A. M.—Pulse 118, respiration 30, temperature 106.8°; skin hot and dry. The fever rose in the evening; patient talked and muttered in her sleep, and frequently awoke suddenly with a start and cry; moans and sighs with every breath; is greatly agitated and alarmed; declares the

case is utterly hopeless, and that her lower extremities feel as if they were paralyzed. Pain in head, back, and limbs intense; nausea constant and distressing, but no vomiting; heavy, disagreeable odor emitted by the body, as in yellow fever; great congestion of capillaries; face and hands of a scarlet hue; an eruption has appeared upon the forehead; the surface of the face, trunk, and extremities is as highly injected and as red as in scarlet fever or measles, but the brilliant redness is more uniformly diffused over the surface than in either of these diseases. Urine abundant; light-yellow color; specific gravity 1020; contains a small amount of albumen, with detached cells from the tubuli uriniferi and yellow granular casts, together with vesical and vaginal epithelium. Upon standing the urine let fall a moderate deposit of urates of ammonia and soda, mingled with the cells and casts. 3 P. M.: Pulse 108, respiration 36, temperature  $106.2^{\circ}$ ; skin hot and dry; face and surface generally of a deep-scarlet hue; pressure drives out the blood from the capillaries and leaves a white spot, into which the blood slowly returns. Tongue coated in center, with yellow fur and red at tip and edges; swollen, with margins indented by the teeth; moist and soft. Nausea, depression, fear of death, and bad odor from the body unchanged. 9 o'clock P. M.: Pulse 112, temperature  $106.2^{\circ}$ , respiration 38; moans and sighs with every breath; when spoken to answers rationally, but often slumbers, starts, and jumps in a delirious, nervous manner; odor from body heavy and offensive.

July 25th, 10 A. M.—Condition unchanged; pulse 118, full and strong; respiration 36; temperature  $108^{\circ}$ . The delirium and restlessness of the patient prevented the thermometer being held well in the axilla; the actual temperature was therefore somewhat above  $108^{\circ}$ , and probably reached from  $110^{\circ}$  to  $113^{\circ}$  in the cavities of the heart. Conjunctivæ congested; gums red and spongy; odor of body very offensive; surface of face, trunk, and extremities greatly congested and

of a brilliant scarlet hue; forehead covered with a distinct papular eruption. Urine light-colored; specific gravity 1020; contains albumen in considerable amount, numerous granular casts of tubuli uriniferi, kidney cells, granular yellow albuminoid matters, and amorphous deposits of urates of ammonia and soda. Two hours after I was summoned to the bedside of the patient, and found her in *articulo mortis*. I was informed that she had started suddenly in a disturbed sleep, made several ineffectual efforts to vomit, and passed immediately into this state. She was unable to swallow. Sinapisms were freely applied, but without effect.

The treatment of this case will be briefly mentioned, although we are not now engaged with this subject. The bowels were first opened with a saline cathartic, followed by quinine. Rest was then promoted by Dover's powder. The bowels were afterward kept open by means of enema. The diet was light but nutritious, and administered in small quantities at regular intervals; the action of the kidneys was promoted by the use of gentle diuretics, as orange-leaf tea and water charged with carbonic-acid gas. Quinine aggravated the delirium, and was abandoned at once. Alcoholic stimulants were found in like manner to aggravate the pain in the head, the nervous excitement, and delirium. Cold wet cloths were applied to the head, and the surface bathed with tincture of camphor and water.

In the last moments of life the scarlet flush of the surface gradually faded, and at the moment of death, which occurred at 1 P. M., the surface presented a yellow, jaundiced hue; after death body mottled; decomposition rapid. I attributed the death of this patient to the high degree of heat and the consequent disorganization of the blood and derangement of the nervous and muscular forces consequent upon the action of the febrile poison.

The fullest and most reliable observations on the pulse in yellow fever with which we are acquainted are those given

by Daniel Blair in his "Account of the last Yellow-fever Epidemic of British Guiana," third edition, London, 1852. According to this accurate observer, the pulse was rarely very quick during any period of the disease. It was highest in the first stage, and gradually declined in frequency. Before death it generally became quicker and smaller, and when much fluid ejections occurred it became extinct at wrist many hours before death. During convalescence the pulse was uniformly slow when no complication existed. "The pulse was quickest in the cerebral variety. In some cases, when the disease determined to the intestines, the pulse became startlingly slow, even on the second day of the disease; thus in Mr. Mackae's case it was 48; he recovered. In case 2895 of Seaman's Hospital, the pulse on the sixth day of fever was 24. The insidious nature of some of the attacks (when the seat of the malady was the intestinal, urinary, or pulmonary apparatus), the perfect ease of the patient, the external air of good health, and the *solemnity of the pulse* in such cases frequently inspired the practitioner with a kind of awe and horror of the new, treacherous, and remorseless malady. In some cases of our late yellow fever it seemed as if the poison acted directly and at once as a sedative on the heart, and in some cases there seemed a sudden and temporary excitability of it, which must have been favorable to the production of fatal local congestions."

The average pulse on the first day of the disease, in one hundred and twenty-one cases, was 97.40; of three hundred and thirty-eight cases, on the second day, 90.80; of four hundred and six cases, on the third day, 83.53; of three hundred and eighty-eight cases, on the fourth day, 80.44; of three hundred and eleven cases, on the fifth day, 78.56; of two hundred and six cases, on the sixth day, 78.74; of one hundred and twenty-five cases, on the seventh day, 78.78; of seventy-one cases, on the eighth day, 75.62; of forty-six cases, on the ninth day, 75.76.

Dr. Blair gives striking examples of the sudden rise or fall of the pulse; thus in one case it rose from 72 in the morning of the third day to 120 in the afternoon; in another, from 112 in the morning to 156 in the afternoon of the fourth day. In one case the pulse fell from 108 in the morning to 54 in the afternoon, and in another from 120 in the morning of the fifth day to 80 in the afternoon. These remarkable differences in the pulse are said by Dr. B. to be rarely accompanied by corresponding febrile exacerbations. There is also, he adds, great irregularity in surface temperature in yellow fever. Sometimes the forehead is the hottest part of the body, and occasionally the cheek. Uncovered portions of the body in the latter stages are easily reduced in temperature; and thus while the exposed chest and extremities may feel cool to the touch, the axilla may raise the thermometer to 102° or 103°. The highest temperature observed by Dr. Blair was 107°. He established the remarkable slowness of the pulse during convalescence from yellow fever by a careful comparison of its rate in convalescence from various other diseases.

Dr. John Davy remarks upon the preceding observations that "slowness of pulse in connection with certain diseases of the abdominal viscera, not of an inflammatory kind, is worthy of remark. Jaundice is a striking instance of the kind. Less marked ones are met with in cases of functional derangement of the primæ viæ, though not without exceptions. . . . Unusual slowness of pulse was often observed in the yellow fever of Barbadoes, and commonly accompanied with undue coolness of skin, especially in the extremities. It was a remarkable feature of the disease after its first invasion, the time varying in different cases."

The following table contains the results of my own observations upon the pulse and temperature in yellow fever, consolidated with those of several other observers; viz., W. Arnold, M. D., Charles Faget, M. D., Just. Touatre, M. D.,



# 144 *Changes of Temperature and Pulse in Yellow Fever.*

and Dr. Thos. Layton. My thanks are especially due to my distinguished confrère, Dr. Faget, for the opportunity of examining the thermometric records preserved by Drs. Touatre, Layton, and himself during the epidemic of 1870.

TABULAR STATEMENT OF THE VARIATIONS OF THE PULSE AND TEMPERATURE IN YELLOW FEVER.

No. Case.	Temp. and Pulse .....	DAY OF DISEASE.										RESULT AND REMARKS.
		1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	
1	Pul.	108	118	118	....	....	....	....	....	....	....	Death on 3d day.
	Tem.	103.5	106.8	108	....	....	....	....	....	....	....	
2	Pul.	110	110	108	100	....	120	....	....	....	....	Death on 9th day.
	Tem.	108	108	108	108	110	110	110	....	100	....	
3	Pul.	120	120	....	....	....	....	....	....	....	....	Death on 17th day.
	Tem.	108	108	108	108	109	110	110	....	110	100	
4	Pul.	....	110	90	....	96	....	....	....	....	....	Death on 11th day.
	Tem.	....	106	107	108	....	108	110	....	110	98	
5	Pul.	110	110	....	....	....	....	....	....	....	....	Death on 7th day.
	Tem.	107	108	....	....	....	....	....	....	....	....	
6	Pul.	100	....	120	....	....	....	....	....	....	....	Death on 3d day.
	Tem.	107	108	109	....	....	....	....	....	....	....	
7	Pul.	....	110	100	140	....	....	....	....	....	....	Death on 6th day.
	Tem.	....	109	109.5	....	110	....	....	....	....	....	
8	Pul.	100	96	....	90	100	100	....	....	....	....	Recovered.
	Tem.	....	105	105.5	....	....	100	....	....	....	....	
9	Pul.	110	100	....	120	120	126	....	....	....	....	Death on 6th day.
	Tem.	109	....	....	....	100	....	....	....	....	....	
10	Pul.	90	85	90	85	....	....	....	....	....	....	Death on 4th day.
	Tem.	105.5	....	....	....	....	....	....	....	....	....	
11	Pul.	100	90	86	86	80	86	....	....	....	....	Death on 8th day.
	Tem.	107	....	....	107	....	....	....	....	....	....	
12	Pul.	....	110	100	90	110	90	....	....	....	....	Recovered.
	Tem.	105	105	105	104	104	100	....	....	....	....	
13	Pul.	....	....	100	....	....	....	....	....	....	....	Recovered.
	Tem.	....	105	100	....	....	....	....	....	....	....	
14	Pul.	118	90	80	76	70	68	60	....	....	....	Convalescent on 5th day.
	Tem.	103.5	101.9	101	99.4	99.4	98.8	98.8	....	....	....	
15	Pul.	118	110	78	70	70	68	60	....	....	....	Convalescent on 4th day.
	Tem.	103	101.4	100	99	99	99	99	....	....	....	
16	Pul.	116	82	84	82	78	76	80	74	60	64	{ Case protracted on account formation parotid abscess; recovered.
	Tem.	103.2	101.8	101.5	101.6	101.6	102.2	100.8	101.2	101.2	99.2	
17	Pul.	86	62	70	60	60	....	....	....	....	....	{ Convalescent on 5th day; veratrum viride rapidly reduced pulse.
	Tem.	104	101.2	101.2	100.2	99.2	....	....	....	....	....	
18	Pul.	102	94	88	80	....	....	....	....	....	....	Convalescent on 4th day.
	Tem.	104.4	100.6	99.4	99	....	....	....	....	....	....	
19	Pul.	126	100	90	94	84	80	....	....	....	....	Death on 6th day; male, aged 67 years.
	Tem.	104.6	104	102.2	102.2	100	99	....	....	....	....	
20	Pul.	110	75	60	....	....	....	....	....	....	....	Male child; convalescent on 3d day.
	Tem.	104.5	101.4	100.4	....	....	....	....	....	....	....	
21	Pul.	120	106	90	82	92	110	90	80	70	100	{ Adult male; on 3d day abscess of elbow commenced; convalescent on 7th day.
	Tem.	104.4	103.5	103.6	104.9	104.8	102.8	101.5	101.2	101	100.8	
22	Pul.	120	80	62	80	70	70	70	70	....	....	Veratrum viride in 20-drop doses rapidly reduced pulse; convalescent on 7th day.
	Tem.	105	101.2	100.4	101.8	99.5	99	99.5	99	....	....	
23	Pul.	120	112	110	76	76	....	....	....	....	....	Adult male, aged 63 y'rs; died 5th day of disease.
	Tem.	105.8	105	104	100.4	98.5	....	....	....	....	....	
24	Pul.	....	100	86	80	70	70	....	....	....	....	Male child; on 4th day an attack of indigestion caused rise in temperature; convalescent on 6th day.
	Tem.	....	101.8	100	100	99	98.8	....	....	....	....	



# Changes of Temperature and Pulse in Yellow Fever. 145

No. Case.	Temp. and Pulse.....	DAY OF DISEASE.										RESULT AND REMARKS.
		1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	
25	Pul. 122 Tem. 102.2	110 103.2	102 101.9	100 100.1	130 100.9	....	....	....	....	....	....	Death on 15th day.
26	Pul. 150 Tem. 103.4	120 104	100 102.5	90 102.2	88 101	100 101.4	70 100.2	84 100	....	....	....	An eruption of urticaria appeared on 5th day and caused oscillation of temperature; convalescent on 7th day.
27	Pul. .... Tem. ....	110 104	98 103.5	84 102.4	80 100.5	80 100	76 98.8	....	....	....	....	Male, aged 31; convalescent on 7th day.
28	Pul. 110 Tem. 103.8	80 104.5	94 103	82 101.8	98 101.5	....	....	....	....	....	....	Adult male; black vomit on 4th day; death on 6th day.
29	Pul. 110 Tem. 103.8	100 104.4	84 103.7	90 103.6	92 102.2	90 101.8	80 102.2	104 102.2	114 102.2	114 98.5	....	Adult male; death on 10th day. On 9th day temperature fell rapidly from 102.2 to 98.5, when pulse increased to 114.
30	Pul. 118 Tem. 104.2	116 105.2	104 104.3	100 104.2	98 103	100 102.8	....	....	....	....	....	Adult male; died on 7th day.
31	Pul. 72 Tem. 101.3	68 102.2	68 101	72 101.5	64 99.8	52 100	48 99.8	48 99.3	....	....	....	Male, aged 19; jaundice on 3d day; convalescent on 9th day.
32	Pul. 108 Tem. 102.2	100 103.8	108 102.2	94 100	80 100.4	70 98.5	70 98.5	60 96.8	50 96.8	44 ....	....	Male, aged 23; convalescent on 7th day.
33	Pul. .... Tem. ....	108 104.5	90 102.6	80 102.8	74 100.8	76 99.6	64 ....	....	....	....	....	Female child; convalescent on 7th day.
34	Pul. 130 Tem. 102.2	120 104	110 104.6	100 102	84 99.4	....	....	....	....	....	....	Female; convalescent on 5th day.
35	Pul. .... Tem. ....	114 103.6	113 101.8	105 104.2	70 103	63 100.2	105 101.6	105 101.3	112 99.2	136 99.8	....	Adult male; jaundice on 4th day, black vomit on 6th, and death on 11th. After the super-vention of black vomit pulse increased in frequency.
36	Pul. .... Tem. ....	120 105	100 105	90 103	74 102	72 62	68 60	78 60	90 59	80 50	....	Adult male; convalescent on 10th day.
37	Pul. .... Tem. ....	108 105.8	90 105.9	80 101.9	80 103.4	60 101.5	60 100	59 99.8	50 99.6	50 100.5	....	Male, aged 27; convalescent on 8th day.
38	Pul. 116 Tem. 106.5	100 106.5	92 105	100 101.6	....	....	....	....	....	....	....	Male, aged 22; temperature fell from 106.5 on 3d day to 101.5 on 5th day; death on 5th day.
39	Pul. .... Tem. ....	85 105.9	96 106.6	110 100	....	....	....	....	....	....	....	Male, aged 35; jaundice and black vomit preceded death. Temperature fell from 106.5 on 3d day to 99.2 on 4th, day of death; pulse, on other hand, rose from 84 to 172.
40	Pul. .... Tem. ....	112 101.8	104 104	100 104	80 102.7	80 102.6	80 102.2	74 101	74 102.6	74 101.2	....	Male, aged 20; jaundice on 5th day; pulse became slow, but temperature rose above normal standard; convalescent on 14th day.
41	Pul. 90 Tem. 103	70 102	84 101.6	64 104.4	70 103.8	70 102.5	60 101	50 99.8	44 99	....	....	Male child; under veratrum rapid fall in the pulse; convalescent on 10th day.
42	Pul. .... Tem. ....	100 106	85 102	94 105	83 104.5	84 103.7	84 100	....	....	....	....	Female, aged 15; temperature was elevated on 4th and 5th days; convalescent 8th day.
43	Pul. 98 Tem. 105.1	80 105.3	76 105	70 103.4	74 102.2	84 101.2	108 100.2	....	....	....	....	Male, aged 40; jaundice 3d day; pulse depressed during jaundice. Temperature fell from 105 on 3d day to 100.2 on 7th, day of death.

146 *Changes of Temperature and Pulse in Yellow Fever.*

No. Case.	Temp and Pulse .....	DAY OF DISEASE.										RESULT AND REMARKS.
		1.	2.	3.	4.	5.	6.	7.	8.	9.	10.	
44	Pul. .... Tem. Fev. 105	112 105	110 104	108 102.2	96 102	86 102	69 101	76 101	80 99.2	68 99.8		Male, aged 32; jaundice and hemorrhage from kidneys; convalescent on 9th day.
45	Pul. .... Tem. Fev. 100	..... .....	..... Fev. 100	82 100	82 100	85 100	80 98	80 98	.....	.....		Male, aged 37; jaundice 3d day; urine loaded with albumen; convalescent on 7th day.
46	Pul. .... Tem. Fev. 105	..... Fev. 105	..... Fev. 104	..... 104	..... 104	130 102.5	140 103.5	.....	.....	.....		Progressive diminution of urinary excret'n: death.
47	Pul. .... Tem. Fev. 101	..... Fev. 101	80 101	72 101	80 100.8	80 101	.....	.....	.....	.....		Black vomit, jaundice, and urinary suppression; death on 7th day.
48	Pul. .... Tem. Fev. 100.5	..... Fev. 100.5	84 101	92 101	80 100	.....	.....	.....	.....	.....		Black vomit, jaundice, and urinary suppression; death on 6th day.

It will be seen from the preceding table that an elevation of temperature above  $106^{\circ}$  in yellow fever was invariably followed by death. In this fact we have a powerful argument for the constant employment of the thermometer in the investigation of the phenomena of this disease, as affording sure grounds not only for prognosis but also for treatment.

In those cases attended with great elevation of temperature the excessive heat should be diminished by those measures which reduce the action of the heart, promote free perspiration, and directly reduce the heat of the surface. The most efficient remedies for this purpose appear to be veratrum viride and sponging the surface with water, or with water, acetic acid, and alcohol, and blood-letting. It appears also that an active purgative, either calomel or castor-oil, followed immediately by one or two full doses of quinine in the first twenty-four hours of the fever, produces beneficial effects in unloading the portal system, and in controlling to a certain extent the production of animal-heat.

The profession needs accurate records of the thermometric changes as influenced in the early stages of the disease by the above measures. The preceding table also illustrates the fact that jaundice, urinary suppression, and black vomit are often accompanied by a slow pulse and but moderate eleva-

tion of temperature. If the thermometric changes of yellow fever be projected upon a chart, and a comparison instituted with the thermometric changes in other diseases, it will be observed that the former more nearly resemble the rapid rise and fall of temperature observed in varioloid, without secondary fever, mild scarlatina, and simple, uncomplicated pneumonia, which runs its course without fresh accessions of inflammatory action, while on the other hand they differ materially from the rapid and oft-recurring elevations and depressions of temperature characteristic of the various forms of paroxysmal malarial fever.

The cause of the rapid rise and fall of the temperature in yellow fever must be sought chiefly in the changes in the blood, and in those organs upon which the circulation and integrity of the blood depend. Neither the rapid rise nor fall of the temperature can be referred wholly to the effects of the poison upon the nervous system.

While it must be admitted that the experiments of Chossat, Brodie, Nasse, Claude Bernard, Brown-Séquard, Budge, De Ruyter, Waller, Schiff, Naunyn, and Quinke, and the experiments of Tscheschichin, in which division of the medulla oblongata near its junction with the pons caused a remarkable elevation of temperature from  $102.92^{\circ}$  to  $108.68^{\circ}$ , and finally convulsions and death; and a large number of pathological observations, in which most remarkable variations of temperature accompany profound alterations and disturbances of the nervous system, without corresponding changes in the respiration and circulation, sustain the theory of *centers of control*, which have their seat in the brain, and which regulate the activity of the spinal cord (when they are destroyed the activity of the spinal cord being morbidly increased, as manifested by increased reflex action, quickened respiration, acceleration of the cardiac systole, and increased animal heat), and that a great part of the pathological phenomena of warmth may be only the expression of the action of the *vaso-motor* nerves;

and still further, that the integrity of the central parts of the central nervous apparatus is more necessary for the regulation of animal heat than that of any other parts of the body. On the other hand, Breuer and Chropak, after an investigation of the question whether the nerves of a part supply elevation of temperature in an inflamed part, by means of experiments on animals, in which they have as far as possible divided all the nerves of one part of the body, think themselves justified in concluding that the force of the traumatic inflammation is independent of the nervous connections of the inflamed part with the nerve-centers; and by an extended series of observations\* I have established the fact that in hospital gangrene and pyæmia the elevations of temperature are independent of the local lesions of the structures, and are coincident with the introduction of the gangrenous and pyæmic poisons into the blood, are intimately associated with the changes of the blood and urine, and are invariably accompanied by increased amounts of such constituents as urea, phosphoric and sulphuric acids; and even the traumatic fever accompanying gun-shot wounds arises from the introduction of inflammatory products into the blood, and depends not so much upon the extent and nature of the wounds as upon the state of the solids and fluids at the time of the injury, and upon the character of the inflammatory products absorbed into the circulation. Even in such inflammatory diseases as pneumonia, attended with extensive tissue change, the introduction of certain inflammatory products into the blood must more or less influence the production of high temperatures.

It is well known that some of the most violent poisons during their direct action upon the nervous system are unattended with elevations of temperature, while on the other hand putrid matters, pus, and certain animal secretions, as

\* Investigations upon the Nature, Causes, and Treatment of Hospital Gangrene, as it prevailed in the Confederate Armies 1861-5, by Joseph Jones, M. D.; Surgical Memoirs United States Sanitary Commission, vol. ii, pp. 146-570.

the poison of the rattlesnake and copperhead, induce profound alterations in the blood, attended with the most marked variations of temperature; and in the latter class of poisons the phenomena appear to be akin to the changes which may be induced by ferments, which are not only capable of increasing the amount of heat, but may be *limited in their actions*, or in the amount and character of the changes which they induce, in virtue of their chemical constitution and that of the blood or medium in which they are active.

Certain substances, as woorara, coffee, musk, and camphor, and putrid fluids have a direct effect in raising the temperature after their entrance into the circulation. Voisin and Lionville, by means of subcutaneous injections of woorara, induced a complete artificial fever in human beings, with rigors, heats, and sweatings, the temperature rising to  $104.8^{\circ}$ , accompanied with all the signs of febrile circulation and secretion and disturbance of the nervous system.

When certain putrid solutions or pus are injected into the blood the temperature rises considerably within two hours, and reaches its maximum in from two to twenty-eight hours. After a single injection rapid defervescence generally sets in shortly after the acme has been reached, while on the other hand, after repeated injections, death constantly occurs, generally with high temperatures. Fluids from inflamed tissues, pyæmic and septicæmic blood, and even the blood drawn in simple inflammatory or other kinds of fever, produce similar elevations of temperature.

Fresse has determined by experiments that the rise of temperature induced by the introduction into the blood of the products of decomposition and of inflammatory tissue destruction do not depend upon the *pus-corpuscles*, nor upon the so-called *germinal matter*, but upon the *serum* of the fluid. *Even boiling and subsequent filtration does not destroy the property*; and the removal of the fibrin, and even the filtration of the blood of animals suffering from fever, does

not deprive it of the pyrogenic effects when injected into the circulation.

The unknown cause which excites the specific morbid process of yellow fever would appear to have something in common with the action of such putrid animal substances, and the fact is worthy of note that the property possessed by such matters of exciting chemical changes and elevation of temperature was not destroyed by boiling and subsequent filtration; for we have thus a clear demonstration that the animalcular, vegetable, or germinal theories as to the origin of yellow fever are not *absolutely necessary* to the explanation of the febrile phenomena.

Neither the rapid rise nor the sudden declension of the temperature in yellow fever therefore are *necessarily* referable *solely* to the effects of the poison upon the nervous system; because, in the first place, the changes of the blood are among the first manifestations of diseased action, and the progress and termination of each case is largely dependent upon the extent and character of the changes of the blood and the degree of temperature; in the second place, the sudden fall of temperature during the succeeding stage of calm may be referred to the peculiarity of the self-limited chemical changes excited by the poison, and to the structural alterations induced in the muscular tissue of the heart and in the liver and kidneys, and the sedative action of the bile, urea, and other excrementitious products retained in the blood, upon the nervous system; and finally the changes in the blood, heart, liver, and kidneys are of a definite physical and chemical nature, and could never be induced by a mere exaltation or depression of nervous action, and must be referred to the introduction and action of some agent or material related in a definite manner, in its chemical constitution and physical properties, to the fluids and solids in which it induces these profound physical and chemical changes.

Without doubt the action of the yellow-fever poison upon

the nervous system may be direct and most important, but the facts do not justify us in locating the origin of the disease wholly in the action of the poison upon the nervous system; and in fact the earliest manifestations of disordered nervous actions, as uneasiness, loss of appetite, and chilly sensations, may be entirely secondary to the changes in the blood, by which all parts of the nervous system are surrounded and supplied.

It is, however, impossible in the present state of our knowledge to refer the changes of temperature in yellow fever with certainty to either the decrease or increase of any one constituent of the blood; for M. Andral\* has shown that when the blood contains more than four one-thousandths of fibrin the temperature rises, and in a corresponding ratio. Thus of all diseases pneumonia is marked with the greatest increase of fibrin, and is the highest in temperature of all the phlegmasiæ. Of eighty-five cases, in only thirteen was the temperature below  $102.2^{\circ}$ ; in forty-four it was between  $102.2^{\circ}$  and  $104^{\circ}$ ; in twenty-six between  $104^{\circ}$  and  $105.8^{\circ}$ ; and in two rose to  $106.16^{\circ}$ . In acute pleurisy, in which there is always less fibrin, the temperature only once reached  $105.8^{\circ}$ , and usually oscillated between  $101.3^{\circ}$  and  $103.1^{\circ}$ . M. Andral, however, records exceptions to this relationship of the increase of fibrin and the elevation of temperature in inflammatory diseases, as in erysipelas, where there have been only seven one-thousandths of fibrin, the temperature has been  $107.24^{\circ}$ ; and he very justly does not consider the increase of fibrin and the rise of temperature as cause and effect; for in the pyrexia, when there is no excess of fibrin, but rather a diminution of this constituent, the temperature is as high or higher than in the phlegmasiæ. Indeed the highest degrees are reached in diseases where there is the least fibrin in the blood. Neither does the number of red globules affect the rise of temperature to an appreciable degree in inflammations

\*Medical Times and Gazette, London, July 1, 1870.



and fevers, as I have carefully determined by a comparison of the constitution of the blood with the elevations of temperature in various diseases.

It is evident therefore that the cause of the rapid rise and sudden decline of the temperature in yellow fever must, as I have said, be sought chiefly in the changes induced by the febrile poison in the BLOOD, and in those organs, as the HEART, LIVER, and KIDNEYS, upon which the circulation and integrity of the blood depends.

NEW ORLEANS, LA.

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## CLINICAL CONTRIBUTION TO DISEASES OF WOMEN.

BY THEOPHILUS PARVIN, M. D.

### I. FIBROUS POLYPUS OF THE RECTUM.\*

Mrs. —, forty-two years of age, a widow, states that for nearly four years she has suffered from pain in the rectum, tenesmus, hemorrhages, and that for some months past the bowel has prolapsed whenever evacuated, requiring her to replace it. Besides—this is her narrative—the bowel comes forward into the vagina and presses against the urethra, causing frequent and sometimes difficult urination. Sitting for any length of time gives her great uneasiness, while a recumbent position is comparatively comfortable. By medical advice she has used astringent injections for the hemorrhage, which is supposed to result from “piles.” No examination, however, has been made.

\*This case was reported at the last meeting of the State Medical Society of Indiana. The reason for its introduction in this series of papers is to be found in the fact that, as in some other rectal disorders, the genito-urinary symptoms were almost as decided as the rectal.





**Fibrous Polypus of the Rectum.**

*Gravée d'après les figures de M. J. B. de la Chapelle.*

The patient lying on her back, with her limbs drawn up, digital examination of the vagina and then of the rectum determined the presence in the latter of a hard polypus, attached by a long, thin pedicle to the anterior rectal wall two inches above the anus. Immediately the tumor was brought outside of the rectum, a ligature applied to the pedicle, and the latter divided below the point of ligation.

The accompanying lithographs very well represent the tumor as to size, appearance, attachment of pedicle, and interior structure. More than a tea-spoonful of serum oozed from the tumor after its removal, and especially after its being split open.

I should mention that the patient had no hemorrhoids, and the hemorrhages which were attributed to them resulted from the polypus. So too the supposed prolapsed bowel was this tumor, forced without the anus so that fæces could pass. This repeated expulsion of the polypus doubtless was the reason for the pedicle being so long and thin; it had scarcely the thickness of a goose-quill.

A notable feature in the case was the occurrence of well-marked rectocele, the hernia being caused by the pressure of the polypus upon the recto-vaginal wall. This rectocele indeed made the genito-urinary symptoms almost as pronounced as the rectal.

*Remarks.* Polypus of the rectum is rare in the adult; still rarer in either adult or child is rectal fibrous polypus. The opinions upon these points of a few authorities permit me to quote. Fabre\* states that "the fibrous structure in these productions has never been met with." Copland:† "I have never observed any possessing a fibrous structure." Warren‡ refers to the rarity of rectal polypi, and records four cases, but does not mention any of the tumors as fibrous. Erichsen,§

\**Bibliothèque du Médecin-Praticien*, vol. xi, page 396.

† *Medical Dictionary*, American edition, vol. iii, page 658.

‡ *Surgical Observations, with Cases*. Boston, 1867.

§ *Science and Art of Surgery*.

however, states that they are generally of a fibro-mucous character. Brinton,\* differing still more widely from other authorities quoted, uses the following language as to intestinal polypi in general: "The interior of the non-malignant polypiform tumors generally consists of a more or less completely developed fibrous tissue." Gross† refers to the uncommonness of polypi in the rectum, and divides them into two classes, "gelatinous, or adenoid, and fibrous;" the former being of far more frequent occurrence. Allingham‡ remarks that "polypi (of the rectum) are usually described as being of two kinds, the soft, or follicular, and the hard, or fibrous; the former being found in children and the latter in grown persons. I quite concur in the statement that the soft polypus is the one always found in children, but I am of opinion that the fibrous variety is rare even in the adult." Subsequently he states that he does not remember meeting in his practice "with more than six distinctly fibrous polypi." Henry Smith,§ in his description of the different forms of rectal polypi, gives none similar to that I have presented.

The *size* of the growth is certainly quite as remarkable as its character. Another fact, to which attention has already been called, was the occurrence of rectocele. Malgaigne, whose investigations of the etiology of rectocele, though made some years ago, have not been surpassed in thoroughness and completeness, does not mention tumors of the rectum among the causes; and yet how obvious the consequence of a tumor of any considerable size in the bowel, pressing against the recto-vaginal wall?

The *diagnosis* of polypus of the rectum, impossible of attainment from *subjective* symptoms, save as a probability, a careful digital examination renders almost absolutely certain. Visual examination too just after the rectum has been emptied

\* Todd's Cyclopedic of Anatomy, vol. v, page 419.

† System of Surgery. ‡ Diseases of the Rectum.

§ Holmes's Surgery, vol. iv, page 858.

by an enema will often permit us at once to detect the growth, if it should chance to be situated near the anus, or have a pedicle sufficiently long for its prolapse.

The *treatment* is comparatively simple: twist off the growth, or cut it off with scissors or knife, if it is small and the pedicle thin; if otherwise, ligate as near the connection of the pedicle and the bowel as possible, and then divide between the ligature and the tumor. And here let me say that Mr. Henry Smith advises, when a ligature is applied, "returning the polypus into the bowel and letting it slough off;" a practice which in many cases must be of doubtful necessity, and may be of positive danger. No one would think in this day for a moment of pursuing such a practice as a matter of choice in uterine polypi; and while the annoyance and the peril from a sloughing mass in the rectum may not be as great as from a similar mass in the uterus, or in the vagina, yet they are of sufficient importance to forbid their being needlessly incurred. It seems to me that the method pursued in the case reported is, where practicable, preferable to Mr. Smith's.

In cases where immediate section or torsion of the pedicle is contemplated, the relatively greater difficulty of controlling rectal than uterine hemorrhage should be considered in forming a decision.

## II. CYST OF THE LABIUM.

Between three and four years since I visited Mrs. —, a lady about twenty-four years of age, married two years, pregnant for the first time, the pregnancy having advanced to the fourth month, the purpose of the visit being to operate upon a tumor situated in the left labium. This tumor was first noticed when she was about eleven years old. At the accession of puberty it increased rapidly for a time, then its growth ceased until after marriage; but since that time it had been constant, until now the tumor, quite as large as

a medium-sized orange, it was feared, would be a serious impediment in parturition.

Upon careful examination I was satisfied that it was a cyst. A portion of the wall was exposed, the sac evacuated of a light, straw-colored fluid, and as large a piece of the wall cut out as I could, and lint passed into the cavity. I was disappointed in not being able to remove a large portion of or the entire cyst; but the patient was exceedingly restless, and circumstances not necessary to explain did not permit the exhibition of an anæsthetic, and my stay at the place of patient's residence was limited to a few hours. Subsequently free suppuration occurred once, or probably twice, in the cyst, but the final result I do not know.

*Remarks.* Labial cysts, especially such as attain the large size of the one above mentioned, are not common. Dr. Thomas, in his admirable treatise, makes no mention of the disease. Courty, the excellence of whose volume can not be too highly appreciated, briefly dismisses the affection, in company with some others, in these words: "I shall not here describe œdema, or phlegmon of the labia majora, or tumors of the dartoid sac, or encysted tumors, serous or purulent; for these diseases ordinarily do not present any peculiar indications." Churchill, on the other hand, gives quite a good description of encysted tumors, along with other diseases of the labia; but the best discussion of the subject I have seen is in Nonat\* and Linas. McClintock devotes a brief space to these tumors, but the largest he mentions having seen was the size of a small hen's egg. Plate XL., fig. 1 of Boivin and Duges's Atlas represents one of these tumors found by Cloquet in a woman fifty years of age, the growth being two inches and a half long and its diameter one inch. This is about the size of the tumor spoken of by McClintock.

It is hardly possible for an encysted tumor to be confounded with œdema or phlegmon of the labium. It has neither the

\* *Traité Pratique des Maladies de l'Uterus.* Paris, 1869.



change of color nor the increase of sensibility of the latter, nor has it the diffused character of the former. Its history too is different: essentially indolent, no constitutional derangement either antecedent or consequent. The tumor is in the majority of instances situated upon the left side. It is painless, and is said to be usually spherical. But this last observation I do not believe applies to the tumor when large; for in the case of Cloquet, and in that of McClintock and in my own, the swelling was much more in the shape of an egg than in that of a sphere; the larger portion, supposing the patient to be standing, projecting downward and forward. The tumor is distinguished from a hernia, as Vial has pointed out, by no prolongation sent between the ischium and vagina toward the abdominal cavity, by fluctuation, by its non-disappearance in the horizontal position, by no impulse being communicated by coughing or straining, etc.

These tumors, it is supposed by McClintock and others, "are in most, if not in all, instances produced by obstruction of the mucous or sebaceous follicles, which exist here in such numbers, or of Duverney's glands." So far as cysts are supposed to be consequent upon obstruction of the vulvo-vaginal glands,\* may we not doubt the statement, since we so commonly see inflammation and abscess consequent upon such obstruction.

In a recent discussion in the Philadelphia Obstetrical Society Dr. Wm. F. Jenks remarked that there were in the labia glands without secretory ducts, which by the abnormal accumulation of their contents might give rise to true "retention cysts," as they were called by Virchow. One difficulty in accepting the hypothesis of glandular obstruction or of excessive glandular activity being the cause of all these cysts is that in some instances, as in the one I have narrated, the

\*We wish authors would call them by this distinctive name, instead of that of Duverney, Bartholinus, or Cowper.

cyst contents are so different from any normal glandular secretion.

The treatment of these cysts should only be resorted to when they are an inconvenience, a positive discomfort, and may be an injury from their size. The simplest method of treating them (it is that to which Nonat and Linas give the preference) is to evacuate the cyst with trocar and canula, then throw in a wine or iodine injection; in a word, treat it as a hydrocele.

Dissecting out the sac is not always easily done, nor is it always free from risk, as Dr. Churchill well remarks. We can incise the anterior surface of the tumor and cauterize the lining membrane, or fill the cavity with lint, where the size of the growth and its extending up the vagina, as Dr. C. suggests, forbid extirpation. Upon the whole, however, the plan first mentioned will be the most expeditious and least painful, and to be preferred in the majority of cases, though of course it is by no means the certain cure that extirpation is. I may mention also that the plan recommended is advised by Guerin in his lectures upon diseases of the external generative organs of the female (Paris, 1864). He believes, however, that the treatment by iodized injection ought not to be resorted to if the cyst extends high up in the vagina; fearing, from the great vascularity of the organ in that part, mortal accidents that have occurred from a similar injection in hydrocele of the neck.

### III. POLYPOID TUMOR OF INFERIOR PORTION OF THE VESTIBULE.

Mrs. —, a widow, twenty-six years of age, has a tumor, rather more than twice the size of a raspberry, growing from that portion of the vestibule situated between the orifice of the urethra and that of the vagina, its body spreading upward so as to half hide the *meatus urinarius*, laterally to the *labia minora*, and downward so as to partially obstruct the vagina.

The exterior surface is bright-red, bleeds readily upon being roughly touched, has an irregular surface—indeed a cock's-comb appearance. At least three years have elapsed since the tumor was first observed. It is not peculiarly sensitive, but is an inconvenience and a source of some distress in urinating. It probably would be a still greater inconvenience and distress were the patient married. Lifting up the growth with a hook it was excised, and then two sutures were passed through the edges on either side, and fastened so as to draw the tissues over the surface from which the tumor grew.

*Remarks.* Two observations are worthy of being made in this connection; viz., the frequency of these growths, and the facility of their reproduction. To prevent the latter, cauterizing the base with nitric acid or with a red-hot knitting-needle, as Dr. Churchill advises, are among the most efficient means. The needle—or indeed, if necessary, a larger piece of metal—can be readily heated for this purpose by an alcohol lamp. The method pursued in the case which I have reported is, however, possibly worthy of repetition in similar cases.

It will be seen upon referring to Sims's Uterine Surgery, pp. 206-7, that this plan, having for its objects more rapid healing and preventing the reproduction of these polypoid growths, is similar to the one pursued by Dr. S. in amputation of the cervix uteri.

It does not seem to me advisable to waste time—out of any mere complaisance to the patient's feelings, who may have a horror of knife or scissors—by trying to remove such a tumor with caustic or astringents. The first thing the doctor knows his attempted kindness may cost him the case; the patient abandons all hope of cure and effort thereto, or seeks another adviser.

Where the tumor is a true polypus, with a small pedicle, it is not probable that it will grow again after removal with wire, knife, or scissors; and this is true whether it be a vulval

or a urethral polypus. It is only when it has a broad base—is a polypoid rather than a polypus—that it is so liable to be reproduced.

One other observation. These growths, as illustrated in the case reported, are not necessarily possessed of remarkable sensibility, notwithstanding the designation under which they have been considered by some, viz., *sensitive tumor of the meatus*. Guerin remarks, in the work already quoted, that just as we speak of *vascular* and of *nervous* papillæ, so there are urethral polypi with predominance either of the vascular or of the nervous element. The former are distinguished not only by their vivid red color, but by their greater size—frequently as large as a cherry or a filbert—while the latter are pale and rarely larger than a small pea, and their peculiar character, almost pathognomonic, is their exquisite sensibility.

INDIANAPOLIS, IND.

## Reviews.

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**The Therapeutic Effects and Uses of Mercury.** By WM. H. DOUGHTY, M. D., Professor of Materia Medica and Therapeutics in the Medical College of Georgia, Augusta.

This is a review of the report of the Edinburgh committee on the action of mercury, etc., on the biliary secretion, published three or four years ago, and forms a part of the Transactions of the Medical Association of Georgia for 1873. The question which so many seem to have regarded as effectually put to rest by the experiments of the committee is argued by Dr. Doughty in a masterly manner. We have not read a paper for a great while written in a more philosophical spirit or with more logical force. The author renders it very evident that whatever may be the final decision in regard to the physiological action of mercury upon the liver, the Edinburgh committee has by no means determined its therapeutic value. If we admit, as is claimed by the committee, that the effect of mercury upon dogs and men is the same, and admit further, what, as we shall see, we are not at all required to do, that mercury diminishes the secretion of bile in dogs, still we may maintain that the medicine exerts a corrective influence over disordered biliary secretion.

The positions taken by Dr. Doughty are, that clinical observation rather than vivisections is to determine the therapeutic virtues of remedies; that we can not always know what the curative effects of drugs will be from their physiological action; that the hepatic effects of mercury are not dependent upon a simple increase of the bile; and he points

out, in conclusion, how observations on the effects of mercury upon the liver may be made. Passing by the first three, which appear to us to be satisfactorily maintained, we shall confine ourselves to a notice of the last, which forms the body of the paper.

Physiology, pathology, and observation of the sick combine, Dr. Doughty shows, to establish the cholagogue effects of mercury. The liver, in the first place, is the only organ having relations with the alimentary tract that furnishes a distinctive pigment, and the secretion is, moreover, easily recognized by reason of its abundance. Physiologists trace the coloring properties of bile down to the fæces in the lower bowel. After a dose of calomel Simon found in them twenty-one per cent. of the organic principles of bile. "Though the bile pigment," says Flint, "can not usually be recognized by the ordinary tests, it is this which gives to the contents of the large intestines their peculiar color, which is lost when the bile is not discharged into the duodenum." Rindfleisch speaks of the senescent blood-corpuscles as losing their coloring-matter, being taken up into the liver-cells, converted into biliary coloring-matter, and removed from the body with the excrement. Rokitsansky says: "The color of the fæces mainly depends upon the color and degree of saturation of the bile. They may be dark-brown, dark-green, black, pitchy, or, in the absence of bile, grayish or clayey."

The intestinal dejections then afford a decisive criterion of the action of the liver, and reveal its condition in respect to health or disease. Mercurials have been held by the profession for many generations to have the power of "conferring biliousness upon the evacuations," and we must believe that this property has been justly claimed for them. If a failure of biliary secretion is shown by the color of the fæces, and if the healthy color is restored by mercury, how is it possible to doubt that the remedy causes the healthy change? And if in ten thousand times ten thousand instances relief has

followed its operation in affections considered bilious, how can we doubt that the events sustain to each other the relation of cause and effect? And so the therapeutic value of mercury would have remained even if the experiments of Dr. Bennett and his colleagues had gone unchallenged. But it appears that they were too hastily accepted by the profession as concluding the point under investigation. Other experimentalists have brought out different results. It turns out in the end that mercury does promote biliary secretion, as physicians have so long insisted. At a meeting of the Gesellschaft der Aerzte, in March last, we learn from the London Lancet for August, a paper was read by Stricker containing an account of some experiments he had made, in conjunction with Dr. Röhrig, on the circumstances influencing the secretion of the liver. The defects of the former methods of obtaining the secretion were pointed out, and a new method suggested, by which it had been demonstrated that the introduction of such purgatives as croton-oil and jalap, etc., as well as calomel, "*materially increased the secretion of bile.*"

Backed by the clinical argument, which Dr. Doughty shows may be urged so powerfully in favor of the cholagogue action of mercury, we suppose these experiments will be held to be conclusive as to the question. Practitioners may now go on with the use of the time-honored remedy undisturbed by the feeling that in giving it in hepatic disorders they are sinning against the light of physiological science.

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**A Hand-book of Medical Electricity.** By HERBERT TIBBITS, M. D., L. R. C. P. Philadelphia: Lindsay & Blakiston.

A book of one hundred and fifty pages on this subject does not pretend to be exhaustive. If one wishes to master the science with all its theories we have a sufficiency of compendious volumes already published.



New points in practice, of which the efficacy is still a matter of doubt, do not concern very nearly the mass of practitioners. They prefer to apply remedies often tried, waiting for the favorable verdict of a number of competent jurors before adopting an agent new and troublesome. This book tersely sets forth well-ascertained facts available for every-day use.

Every one at all conversant with the effects of electricity will confirm the statements of Mr. Tibbits as to its unrivaled powers in nervous diseases. He has responded very satisfactorily to the demand for a clear description of apparatus, while his account of manipulation is especially to be noted for its highly practical character and the consideration shown for the comfort of the patient. Cases are cited to show when this agent is called for in preference to all others, and also when it may be hopefully resorted to after other remedies have failed.

J. W. H.

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**Report of Columbia Hospital for Women and Lying-in Asylum, Washington, D. C.** By J. HARRY THOMPSON, A. M., M. D., Surgeon-in-Chief. With an appendix. Washington: Government Printing Office, 1873.

The republic of medicine is to be congratulated when any of the funds of our political republic are expended so wisely as in the publication of this valuable volume. Handsomely illustrated and well printed, it is honorable to public liberality and to the medical gentlemen connected with the hospital and its dispensary.

Dr. Thompson, whose surgical ability is abundantly shown in this report of the hospital, is ably sustained by the dispensary staff—Drs. Ashford, Busey, and Prentiss—whose contributions are equally creditable with his own.

And yet the book is not faultless. It is needlessly, wearisomely large; made so by too many cases\* given in detail, and by long quotations from text-books that lie upon our tables or stand upon our shelves, and by other quotations illustrative of the mere rhetoric or of the curiosities of medical literature. Indeed the passion for quotation seems to have been so strong in Drs. Thompson and Ashford, and their love for Tyler Smith's "Leucorrhœa" so great, that each gives sentence after sentence, almost page after page, precisely the same, from this work. In the discussion of *vesico-vaginal* and *recto-vaginal fistula*, most of the space is occupied by Dr. Sims's *silver-suture* address before the New York Academy of Medicine, undoubtedly the poorest of Dr. S.'s many and most of them contributions of the highest value to operative gynecology. Nearly fourteen pages are occupied with an extract from Morgagni, narrating cases of the introduction of foreign bodies into the bladder on the part of females. Billroth, Rokitansky, and Rindfleisch are drawn upon largely in the consideration of *cancer*. Now we do not believe such free quotation adds to the value of a hospital report. It gives any book a sort of patch-work character, when really this is exceedingly valuable without such additions. Dr. Thompson is not so poor—nay, he is rich in knowledge and ability—nor are his materials so sparse that he should need such adventitious aids in making a book; nor is writing a book for the profession the same thing as lecturing to a class of medical students.

Again, Dr. Thompson is not always accurate in his statements; *e. g.*, he asserts (page 45) that prior to Dr. Sims's operations for vesico-vaginal fistulæ "there was no record of a single successful case." Dr. Sims's first publication was in 1852, and in it he gives Dr. Hayward, of Boston, the credit

\*Some of the cases reported too seem to have no special fitness for a report of a woman's hospital—*e. g.*, *extirpation of the parotid gland*; so too *removal of the hypertrophied third lobe of the thyroid gland*.

of having "the first successful case in this country."\* Mr. Henry Earl had up to 1829 succeeded in three cases; one of them he had operated on thirty times.† Malagodi, in 1828, operated successfully. The case is reported in the *Lancet*, September 5, 1829. Mettauer‡ in 1830, Gosset§ in 1834, and Dieffenbach|| in 1836, also succeeded in this operation; nor are these all the successful cases on record occurring prior to Dr. Sims's first successful operation.

Time will not permit us to refer to all the topics presented in Dr. Thompson's report, but some of them we shall briefly glance at. The first paper is upon *ruptured perinæum*. Dr. T.'s method of operating for this injury is fully set forth in the *American Practitioner*, June, 1870. There were also published with it two of Dr. T.'s illustrations; one being of the anatomy of the parts concerned (and unconcerned too, for that matter), and the other showing the vivified surfaces and the sutures introduced; the latter cut almost a fac-simile of one found in Baker Brown's *Surgical Diseases of Women*. Dr. Thompson follows in the main Mr. Brown's method of operating; save, instead of dividing the sphincter ani on each side of the coccygeal attachment, he paralyzes the sphincter in this way—"introducing the thumbs into the anus, seizing the nates on either side, and making gradual traction until the thumbs touch the tuber ischii." How much traction *the thumbs touching the tuber ischii* (which one is not mentioned) can make is a problem we shall not attempt to solve. We do not believe Mr. Brown's method of operating is at all comparable in simplicity and facility of execution to Dr. Emmet's; nor do we believe with Dr. Thompson that the knife is preferable to the scissors for vivifying the surfaces

\* Dr. Hayward's first successful case was in 1839.

† See Hayward's *Surgical Reports and Miscellaneous Papers*. Not equal to Wutzer, for he operated on one case thirty-three times.

‡ *American Journal of the Medical Sciences*, 1847. Dr. Hayward's case was reported in the same journal, 1839.

§ *Lancet*, November 29, 1834.

|| *Lancet*, August 27, 1836.

to be brought in apposition. Nevertheless it is justice to him to say that his success has been both remarkable and highly creditable to his skill and ability.

We pass the weary, needlessly protracted record of cases to come to the subject of *vesico-vaginal* and *recto-vaginal fistula*.

Dr. Sims, as we have said, is the contributor of considerably more than half the number of pages under this head. The portion which Dr. Thompson furnishes includes two cases, one of *utero-vesico-vaginal fistula*, the other of *vesico-vaginal fistula, with entire loss of the urethra*. *Rectocele* and *cystocele* follow. Dr. Thompson's method of operating—and a most successful one it is—for these troubles is, as given in the author's words (he is speaking of *rectocele*, but the principle applies equally to the other): "The patient having been placed in the position for lithotomy, and brought under the influence of an anæsthetic, an incision is made through the whole thickness of the vaginal wall to the cellular tissue connecting it with the rectum. A steel dilator is then introduced through the opening, and by pressing the handles the blades open, gradually separating the rectum from the vagina to the extent desired. This method of dissection is preferable to the knife, it being bloodless and, if carefully practiced, without danger. I am indebted to my friend, Dr. Thomas, of New York, for this idea. The instrument is similar in construction to an ordinary glove-stretcher. The part to be removed having been thus separated from its deep attachments, a pair of strong, blunt-pointed scissors are introduced and the flap cut out. A separated margin of at least one quarter of an inch should be left for adhesion, which when united forms a raphe, and adds materially to the strength of the part. The sutures are introduced at spaces of one eighth of an inch, and are carried back so as to include the whole of the margin which has been separated. Great care must be taken in the adjustment of the parts; the approximation must

be perfect or the operation will be a failure. The sphincter ani must be paralyzed in the same way as recommended in restoration of the perinæum, and the bowels kept loose. The wires are removed from the twelfth to the fifteenth day. The vagina must be frequently washed out with tepid water, and a little carbolized glycerine thrown in after each injection. This operation is simple, and, if properly performed in cases of uncomplicated rectocele, is always successful."

It will be observed, by turning to Dr. Thomas's work on *Diseases of Women*, third edition, page 347, that Dr. Thompson's method of operating is an important modification of "Thomas's Operation for Narrowing the Vagina." Unfortunately Dr. Thomas has not found this operation a certain remedy for uterine prolapse, for two out of his five cases had relapsed when his work was published, and possibly the other three have by this time! Nevertheless there is no reason to believe that cystocele and rectocele may not be thus cured even if uterine prolapse is not, and Dr. Thompson's remarkable success demonstrates the value of his method.

On the 70th page the author has a chapter having at its head "Diseases and Displacements of the Uterus," and then a list of disorders commencing with "Prolapsus" and ending with "Pelvic Cellulitis, etc.," the first sentence of the chapter being, "Without due reflection, it appears remarkable that the uterus should be subject to such a long list of ailments as above enumerated," etc. Pelvic cellulitis is not generally considered a disease of the uterus. The writer then indulges in some very familiar physiology as to menstruation, which might not be out of place in a text-book, and which would be eminently proper in a lecture to first-course students, but ought to have no place here.

In incomplete prolapse of the uterus, with engorgement, Dr. Thompson advocates the use of hot water by injection upon the neck of the womb, for fifteen minutes, morning and

evening; cotton soaked in glycerine applied after each hot bath; pure carbolic acid once a week applied to the cervical canal for the endo-cervicitis; the administration of tonics, especially commending the "syrup of the phosphates of ferrum, quinia, and strychnia" (why not iron instead of ferrum?) He states that "there are very few cases of prolapsus in the first stages that will not yield to this treatment in two or three months." Should the vagina remain relaxed after the uterus is reduced to its normal size, use a weak current of electricity daily, what form is not mentioned. In the second stage of the disease, where the os is at the vulva, he generally amputates the vaginal portion of the neck, afterward, if it is necessary, narrowing the vagina.

In the narrative of cases of *prolapsus uteri* we regret to find the following prescription:

R. Butyrii cocoæ, . . . . 3 ij;  
 Aq. ext. opii, . . . . gr. xij;  
 M. Ft. suppos., No. vi.

Of course the second ingredient should be written ext. opii aq.; and as to the first, *butyri*, not *butyrii*, is the genitive of *butyrum*; while the genitive of *cacao*, not *cocoa*, as Dr. T. makes it, is *cacaonis*. These may seem little matters; but if our masters will not write Latin prescriptions correctly, how are we of the common herd to succeed in this, and had we not better try to write in plain English?

In the treatment of uterine cancer, Dr. Thompson has "found pure bromine more effective than any other caustic in arresting rapidly destructive ulceration." To destroy the fœtor of the discharges he uses bromo-chloralum.

We have not space to present the author's view of *diseases of the vagina and of the neck of the womb*. Following their consideration is a most interesting case of removal of the handle of an iron crotchet-needle from the bladder, which had become incrustrated by urinary salts. The removal was effected through a vesico-vaginal incision.

*Urethral caruncles* are briefly considered. He speaks of them as "essentially recurrent, repeatedly returning after the most thorough and careful removal." "If not painful or inconvenient, *leave them alone.*" In the name of good taste and professional propriety, what doctor objects to their solitude and wishes to remain with them? We profess our utter detestation for the caitiff who covets caruncular companions, refusing to "*leave them alone.*"

Three cases of "*pelvic cellulitis*" are reported, but really the first two read wonderfully like cases of pelvi-peritonitis. *Diseases of the rectum* occupy the last part of Dr. Thompson's work, and their consideration is quite as interesting and valuable as any thing which precedes.

The dispensary reports constitute the appendix. The first of these is by Dr. F. A. Ashford, and is upon diseases of women. He presents "a condensed synopsis of cases" treated since 1869, embracing sixteen hundred. This presentation he thinks he may well begin "under the aphorism *uterum mulier est.*" If this *fragment* of an aphorism can be translated at all, it would be *uterum is a woman*; but such translation is not less absurd than the original. If Dr. Ashford thirsts for a display of his classic lore, why does he not say *E pluribus unum*, and be done with it? The subjects discussed by Dr. Ashford are *acute metritis*, *chronic metritis*, and *endo-metritis*. These subjects are fairly presented, but nothing is offered in therapeutics worthy of note.

Dr. Busey follows with an admirable report from the Department of Diseases of Children. It is really the best paper in the volume. It embraces three articles: the first, intermittent fever; the second, enterocolitis, cholera infantum, dysentery, and difficult dentition. The third is upon the value of certain drugs in the treatment of bronchitis. We regret being compelled to pass Dr. B.'s paper with this brief reference.

The final report is from Dr. Prentiss, a short notice of



which from a friend, Dr. James Thompson, of Indianapolis, much better qualified for its consideration than we are, is here introduced:

"The section on ophthalmology and otology commences with a sadly interesting case of 'rupture of both eyes,' the patient being a 'respectable German woman, aged forty-two years.' The fingers of a scoundrel were thrust into her eyes, which ruptured them both at the inner corneal borders. Vision was totally and permanently destroyed.

"*'Herpes of the cornea'* then claims attention. Thirty-eight cases were treated; seventeen were cured, nine were seen but once or twice, so that the result was not known, and the remaining twelve cases were improved, some of which are still under treatment. The treatment advocated is soothing during the acute and mildly stimulating or irritant during the chronic stages. Atropine, pressure-bandage, etc., for the former; calomel, yellow oxide of mercury, etc., during the latter; cod-liver oil and syrup of the iodide of iron, or citrate of quinine and iron, constitutionally. The reporter remarks: 'The sulphate of zinc collyrium, which is almost a panacea for all inflammations of the eye in general practice, is especially to be deprecated in the earlier phases of the disease now under consideration.' One might add that nitrate of silver and acetate of lead are equally if not more dangerous during the stage spoken of, especially the lead.

"The remainder of the report is taken up with trachoma, its pathology and treatment. The report contains nothing of interest to the specialist. Indeed, one could not expect much where but one hundred and ninety-six cases were seen during a period of nearly three years. It was simply written 'in accordance with a request,' and for the purpose (one may presume) of showing what the hospital had accomplished during that period. To the general practitioner, who has not perused the more recent text-books on the eye, it contains valuable information."

In conclusion, while we have not hesitated to criticise where criticisms seemed needed, yet we are glad to commend the general scope and character and most of the details of this report. Its authors merit the thanks of the profession.

T. P.

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**"Refraction and Accommodation: A Review of Dr. D. S. Reynolds's Critique on Dr. C. S. Fenner's Pamphlet."**

The August number of this journal contains under the above heading a reply to a review that appeared in the July number. The respondent thinks your reviewer treated him rather severely; that the criticism was in part erroneous, besides being irrelevant. Of this the reader must be the judge. But to remove the impression that we have been hypercritical we propose to look a little further into that occult science which Dr. Fenner says the Germans have built up in the last quarter of a century.

The theory that the ciliary muscle effects the change of refraction in the eye during accommodation for near vision was very ingeniously put forth by Porterfield in his "Treatise on the Eye," published in 1759. Thomas Young published in the Philosophical Transactions for 1801 a demonstration of the change of form in the crystalline lens during accommodation. So early as 1793 Dr. Young was convinced of "the muscular character of the fibers in the lens." In 1872 Prof. McNamara, by careful microscopical research, confirms the observation that "the fibers in the crystalline are muscular, and that the change of form during accommodation is due to an inherent power resident in the lens" itself.

As to what influence the ciliary muscle has in effecting the change in accommodation, the question progressively loses interest, since it is known that division of this muscle does not in the least interfere with the accommodative effort.

It has long been known that the relations between the ciliary bodies and the periphery of the lens do not change in any manner during accommodation; and further, that the circumference of the lens undergoes no diminution. (Donders, page 27.)

Dr. F. says: "The lessening of the transverse diameter of the eyeball by the action of the recti muscles exerts a direct pressure on the equator of the lens, and renders it more convex than it can be made by the maximum tension of the ciliary muscle." He then gives directions for proving that accommodation for near vision ("one and a half inches") is due to the above-explained action of the recti muscles, thus shutting the ciliary muscle out from any claims it previously had to the rank of "accommodation muscle."

Dr. F. quotes Wells to show that Donders ascribes amblyopia to the presence of astigmatism in many cases. Now Donders, in speaking of a case in his practice which had for three years been regarded as amblyopic, says: "This is one of the thousands in which astigmatism has been looked upon as amblyopia, and has been treated as such." Again, in treating of the differential diagnosis of the two affections, Donders says: "In astigmatism, on the other hand, in contrast to amblyopia," etc., "the disturbance of vision connected with this anomaly is neither to be compared with that proceeding from defects of the retina (amblyopia)." He distinctly disclaims any other effect from glasses in the treatment of amblyopia than that of magnifying the image of objects on the one hand, and powerfully stimulating the dormant retina with concentrated light by means of strong convex glasses on the other. Graefe says, in his clinical lectures on amblyopia and amaurosis: "In the more favorable and curable forms of amblyopia there must exist anomalies in the circulation or nutrition." Without visible pathological change, "all cases are due to an impairment of function in the retina." Such is the verdict of Stellwag, Wells, Lawson,

Laurence, and, in fact, every writer on the subject for the last century, with the single exception of Dr. F., who says: "Many cases of amblyopia are now entirely relieved by neutralizing the aberrations of refraction by appropriate lenses." Unfortunately, however, he does not tell us who relieved a single one of the "many cases."

The optometer of which Dr. Fenner speaks as invented by Graefe was described in Porterfield's "Treatise on the Eye" just sixty-nine years before Graefe was born. And it may not be uninteresting to know that Huygens, the Dutch astronomer, who died in 1695, really invented the wire optometer used for the measurement of the range of accommodation, with which Porterfield has pretty generally, though erroneously, been credited.

Dr. F. described another means of detecting astigmatism, which is so strikingly original that we can not refrain from reproducing it. He says, "Another method is by making numbers of groups of three lines, parallel to each other, diverge from a point like the spokes of a wheel." How he gets the groups of lines, and how he makes them diverge, we are curious to know. In the *American Journal of the Medical Sciences*, January, 1867, Dr. John Green, of Saint Louis, gives an account of a new method for "the detection and measurement of astigmatism," by the use of "twelve sets of triple radiating lines printed upon a circular card, and corresponding to the twelve hours of the clock." This, it is supposed, is what Dr. F. referred to as one of the recent German inventions.

On page 4 of the "treatise" we find the following: "If we take a small object (No. 1 Snellen) and hold it at the furthest distance at which the normal eye can distinctly and sharply see it, we have the far point ( $r$ ), and this represents the natural refractive state of the dioptric apparatus." If Dr. F. means No. 1 of Snellen's test-letters, then the distance at which the letters are seen, at an angle of five minutes, is twelve inches.

And this not only does not "represent the natural refractive state," but, on the contrary, represents the maximum degree of tension of the accommodative apparatus that it is possible to maintain long enough to read even for a few minutes without a sense of fatigue. Helmholtz says: "The natural refractive state of the dioptric system is that state in which no accommodative effort is required to complete the act of vision—the state of the normal eye for vision at all distances beyond eighteen or twenty feet."

Dr. F. says he has by a large number of tests ascertained that most persons of the South and West have a normal visual angle of four minutes; and winds up by announcing that "an angle of five minutes is the smallest one (except in small children) at which the Germans and some other European nations can ordinarily see with distinctness." Snellen's are the test-letters in universal use in Germany, and, in fact, in most countries. These letters are "composed of limbs just one fifth the diameter of the letter's height; for instance, our letter C shows an opening as compared with the O of one minute visual angle. In testing accuracy of vision we accept *perfect recognition* and *not* uncertain perception." This is the language of Snellen, whose test-letters are printed in English, French, Italian, German, and Dutch.

As to Dr. F.'s intimation that small children have a smaller visual angle than adults, it is about as probable as that the people of the "South and West have a normal visual angle of *less* than five minutes;" when to distinguish a letter whose area covers an angle of five minutes the limbs of the letter are actually seen under an angle of one minute by the English-speaking nations, and by the Germans, French, Dutch, and, in fact, every civilized nation on earth. Children, whether large or small, require an angle equal to more than twenty times that required by adults for distinct vision. This gradually diminishes from infancy up to the tenth year, when the angle is generally found to have arrived at the normal state—

five minutes—for continuously exercising the visual power, as in reading or the like.

Dr. F. insists that convex glasses of seventy-two inches focus are quite sufficient for the preservation of good vision for many years in cases of presbyopia. In other words, if No. 72 be selected as the proper glasses, "the rapid senile changes in the crystalline lens are prevented," whereby the further development of presbyopia is arrested, and age is no longer permitted to manifest its advance in the growing defect of vision. This will be pleasant news to the old people whose eyesight is beginning to fail.

We were made to say in our review that "Airy discovered compound irregular astigmatism." We wrote "regular" astigmatism. As Dr. Fenner failed to point out the mistake, we deem it proper now to correct it. But we must not take up more of the time of our readers on points which, however interesting to Dr. Fenner and the writer, can hardly be expected to interest the majority of practitioners. D. S. R.

## Clinic of the Month.

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MIND, BRAIN, AND SPINAL CORD.—The Croonian Lectures for 1873 were delivered by Dr. C. B. Radcliffe, a physician whose writings on nervous disorders are familiar to most American practitioners. The subject selected by the learned lecturer, "The Mind, Brain, and Spinal Cord in certain morbid conditions," was one for which his studies and tastes seem to have peculiarly fitted him. We do not remember ever to have seen it handled in a more striking way. Our only regret is that our limited space does not allow our copying the lectures entire.

*"On Delusion."*—Delusion is not an indefinite disorder of the intellect and fancy coming on, no one knows how, without warning of any kind, but a very definite disorder, taking many shapes, each of them associated with some morbid mental condition from which it can not be dissociated, and often receiving this shape, as it would seem, as a natural consequence of the mind having been allowed to go wrong in the direction of some particular morbid mental condition, intense self-conceit, misanthropy, melancholy, or other. Nothing is more certain than this, that by indulging in a perverse way of feeling or thinking, sooner or later, the reason and will are mastered by this feeling or thought, and that when this point is arrived at the feelings and thoughts and actions, as a matter of course, become more or less irrational and involuntary. Arrived at this point indeed, any delusion, any fancy may easily take undisputed possession of the mind. And thus the delusion, instead of being something almost unintelligible, becomes little more than a natural consequence



of the unresisted continuance of the particular morbid mental condition with which it is associated, and from which it can not be disassociated.

"If the mind be allowed to rest too long in any of these morbid mental conditions which are constantly associated with delusion, the will and reason are deposed and feeling is enthroned in their stead. This is all; for when feeling is raised above will and reason the result of necessity is not only disorder but delusion. And thus insanity becomes somewhat more intelligible, inasmuch as it reduces itself to little more than the natural consequence of the mind having been allowed to go wrong in the direction of some perverse feeling until a point is arrived at in which the will and reason have no longer any control over it; an end in which—for all the unchecked evidences of the mere feelings are delusive—delusion in one form or another is the inevitable result.

"And if delusion take these different forms, and is brought about in these different ways, it is plain that there are several very definite indications of treatment, which may be followed out in a very hopeful spirit. The case is not one in which delusion is no one knows what, coming about no one knows how, in which the physician is left in a state of uncertainty as to what ought to be done to prevent it and to cure it. The case is definite enough. There are several morbid mental conditions, as intense self-conceit, misanthropy, melancholy, uncontrollable impulsiveness, and the rest, preceding insanity, continuing when insanity is actually developed, and each of them leading naturally to the delusion which is the conclusive evidence of insanity. There is, in fact, a definite morbid mental condition other than delusion to be dealt with. By dealing with it delusion is to be prevented; nay more, by dealing with it delusion is to be counteracted and conquered. It is as much a duty to deal seriously with this morbid mental condition as it is with the actual delusion; for delusion is the natural consequence, sooner or later, of leaving it to itself.

Every effort must be made to teach the patient that he is responsible for his feelings and thoughts as well as for his actions; that he can and must master them; and that if he does not try, his will and reason may soon become too powerless to prevent his feelings and thoughts and actions from becoming involuntary and irrational, as in insanity. He must be helped and made to try to do all this in every possible way. A proper mental discipline must be enforced, upon the details of which I can not and need not enter.

"Nor is a different course to be followed when matters have gone further wrong, and there is actual delusion. Certainly all is not done in this case when the lunatic is provided with a comfortable home, and when every conceivable care is taken of his body. All this is wanted, and more also—much more, if what I have said about mind be true. What is wanted is that medical and clerical aid should be brought into closer conjunction than they are at present, with clearer notions in both physician and clergyman as to the autocracy of *mind*. What is wanted is the co-operation of educated persons, similarly enlightened as to mind, who will as a labor of love tend upon the lunatic, giving him the helping hand which now in so many instances they are giving to the ordinary sick. What is wanted also are more carefully-trained ordinary attendants. With respect to the ordinary nursing of the insane indeed a great revolution is necessary, akin to that which is being brought about in ordinary nursing by Miss Nightingale, by the Misses Merryweather, and by their fellow-philanthropists."

*Concerning Neuriasis*, a term which Dr. R. proposes to give to a disorder half nervous, half mental, underlying hysteria, hypochondriasis, and certain other affections akin to them, he says, in a recapitulation of the subject:

"Respecting the physical and mental peculiarities of neuriasis, among the former will have to be placed proneness to pass large quantities of pale, limpid, neutral urine under any

emotion or excitement, or after it, with a frequent irresistible *besoin d'uriner*; proneness to abdominal flatulence, *pneumatose intestinale*; proneness to fits of laughing and crying without sufficient reason for them; proneness to globus, proneness to overflow of saliva, proneness to constipation, together with tenderness on pressure, with more or less uneasiness, or actual pain apart from pressure, in one or other part of the abdomen, or under the left nipple, or somewhere in the course of the spine, with a marked disposition to spasm and periodicity in one form or another; and among the latter or mental peculiarities undue self-sensitiveness, overpowering craving for sympathy, quick and perverse likes and dislikes, feebleness of will, showing itself in impulsiveness and in many other different ways; fancifulness, imitativeness, unbalanced spirits, the inclination being commonly toward despondency; and lastly, a comparatively feeble sense of moral obligation.

"Few in the present day will be prepared to contend that the womb has any special connection with hysteria, or the liver or any other abdominal viscus with hypochondriasis, or to doubt the correctness of the view which regards both hysteria and hypochondriasis as disorders, closely allied, of the nervous system. Still it may be doubted whether, practically at least, the latter view is as clearly realized as it ought to be—whether the word hysteria does not still retain a good deal of its old meaning, and not unfrequently mislead effectually in practice. At all events, hysteria and hypochondriasis can be no fitting names for that general derangement of mind and body of which I have been speaking; another name is evidently desirable which will point away from the womb or liver or other abdominal viscus to the nervous system; and hence my excuse for proposing the term *neuriasis*. I hope, however, that a time will come before long—the time is not yet ripe, I allow—when it will be possible to get a step further than this, and choose a name which will include the *mental* as well as the *nervous* half of the disorder in question;

for I can not help but think that the *nervous* trouble is the effect rather than the cause of the *mental* trouble. Nay, I am even sanguine enough to hope that eventually, by the institution of a sound discipline in which the mind is taught, chiefly through the influence of wise mothers acting upon it in the morning of life, to know and exercise its high powers of subjecting the feelings and thoughts as well as the actions to sound reason and will, that mankind may be delivered not only from the evils of neuriasis, but even from the still graver evils of actual insanity."

FUMING NITRIC ACID FOR INTERNAL PILES.—Prof. Billroth records twenty-six cases of prolapsing piles treated by him in various ways. In four instances he applied the actual cautery, in ten the galvano-cautery, and in the remainder fuming nitric acid. The latter plan was pursued as recommended by Dr. Houston, of Dublin. The results proved eminently satisfactory. His mode of proceeding was as follows: A free evacuation of the bowels was obtained by means of castor-oil given the day previously. Before the operation the mass was brought down by an injection. The patient was then placed on the side, with the knees flexed. The parts adjacent to the anus were first well protected by oil, so that no injury should be done them. A small piece of wood was then dipped in the acid and applied to the outside of the swollen mass, until it had become tolerably stiff, and had assumed a yellowish-green color. It was then smeared with some simple form of ointment, and returned within the sphincter. The operation was usually performed without an anæsthetic, and an opiate suppository was rarely given afterward. It is proper to keep the patient in bed. Fever rarely follows, though retention of urine is not uncommon for the first few days. The eschar usually separates without loss of blood. It is proper to give castor-oil on the third or fourth day, provided no fæces have passed. Hemorrhage will be

likely to occur if the fæces become hardened; such accidents, however, are readily controlled by ice. Of the patients treated in this way some were discharged on the fifth and ninth days, though severe cases were under treatment from six to eight weeks. Several of the patients were examined a year after the operation, and there was no stricture in any one of them. Billroth believes that in very severe cases this treatment may fail, and then suggests the use of the acid nitrate of mercury, as recommended by Curling. (*Wiener Med. Wochenschrift*, No. 35, 1871.)

ISNARD ON THE TREATMENT OF CONSTIPATION BY ARSENIC. Dr. Isnard (*Marseille Médical*, 1872) states many other physicians besides himself have observed that arsenic excites the appetite and improves the digestion and facilitates the action of the bowels, but he is not aware that it has been methodically applied for the relief of constipation. Besides (1) improving the appetite, it (2) excites the muscular action of the intestines, and (3) it augments the secretions of the alimentary mucous membrane. It is particularly useful in the constipation of debilitated and anæmic females, sedentary persons, and old people. He administers arsenious acid in the dose of six to ten milligrammes, twice or thrice a day, with food. Sometimes smaller doses suffice. It may be used steadily for some time.

DIGITALIS AN ANAPHRODISIAC.—M. Gourvat, in the course of a paper published in the *Gazette Médicale de Paris* on the action of digitalis, says: "When digitalis or digitalin is administered for some time to a man in full possession of sexual powers, these become gradually weakened, the propensities disappear, formation of the liquor semenis diminishes, and may at last cease altogether. The anaphrodisiac properties of the drug are the secret of its good effect in spermatorrhœa."

### **Notes and Queries.**

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**BROMO-CHLORALUM IN THE TREATMENT OF VAGINAL DISCHARGES.**—Dr. Melvin Rhorer, of Louisville, has been using for some time back bromo-chloralum as a topical application in vaginal discharges with a success which leads him to esteem it an agent of considerable value in this class of cases. Owing to its antiseptic as well as astringent properties, he regards it of especial value in such discharges as are accompanied by fetor. He applies it in certain conditions, undiluted, directly to the seat of the disease by means of pledgets of lint; at other times he uses it as an injection or wash of varying strength, beginning generally with one part of the ordinary solution to eight parts of water. Dr. Rhorer writes:

"In leucorrhœa, an affection in which I have had frequent opportunities to try it, when associated with anæmia, chlorosis, or merely a lax state of fiber, I have usually met with very marked success, combining a course of general tonics with the local treatment. Before using the bromo-chloralum the vagina should first be thoroughly cleansed by injections of tepid water, made best by means of a Davidson syringe; after which about a pint of the injection, one to eight, should be thrown well into the canal one or more times daily. The discharge is generally diminished, and sometimes is arrested altogether, by the first injection. Occasionally, however, no effect whatever is observed, when I am in the habit of increasing the strength of the injection up to the point of producing decided burning or even pain after its use. In leucorrhœa depending on ulceration of the os the bromo-chloralum should be applied undiluted, on pledgets of lint, immediately to the

seat of the trouble. By this means I am certain that in some cases at least I have accomplished more than I have done with nitrate of silver or carbolic acid, especially where the lesion was not attended by much loss of substance, but consisted of simple erosions.

"Gonorrhea in the female I have also sometimes found to be promptly arrested by this agent. In cases where the inflammation is considerable, and the parts swollen and tender, injections of almost any kind cause, it is well known, great pain. Here before using the remedy it will be necessary first to reduce the inflammation by hot applications, hot hip-baths, injections of warm water where these can be borne, and by constitutional means. Gonorrhea frequently persists by reason of the seat of the disease not being reached by our remedies. It is therefore indispensable to any full measure of success that frequent examinations of the parts involved—the vulva, vagina, and os—should be made, in order to see whether our remedies are being properly applied. Where the disease affects the vulva, vaginal canal, and urethra alone the injections may safely be intrusted to the patient. The same may be said of the management of lint or cotton when used to keep the lips of the vulva apart; but when the disease is deeper seated, affecting the os or the cul de sacs, it will generally be found necessary that the physician should make the injections with his own hand. From a neglect of this precaution cases which had hung on for weeks yielded in a few days.

"Allow me here to insist on the necessity of making all injections into the vagina while the patient is in the recumbent posture. As ordinarily done—stooping over a vessel and injecting with an ordinary syringe—the fluid often escapes without reaching the parts affected. A bed-pan placed beneath the patient's hips will prevent the clothes being soiled. Gonorrhea of the vagina has generally yielded to this treatment in from eight to ten days. Gonorrhea in



the male has not yielded to the bromo-chloralum, the urethral mucous membrane in the male being too sensitive to admit the use of the remedy of a strength capable of doing good.

"In uterine carcinoma the bromo-chloralum will promptly arrest fetor; while in clots of the uterus, and in the fetid discharges which succeed abortions and labors, I much prefer it to the ordinary disinfectants, such as bisulphite of soda, permanganate of potash, etc.

"Bromo-chloralum may, when it is desirable, be combined with other therapeutic agents. We have sometimes thought that the addition of opium or some of its salts has increased its efficiency in certain cases marked by tenderness. Finally it recommends itself by its cheapness."

**CHOLERA.**—Cholera is disappearing from all the places in our country where it has prevailed, and is not breaking out at any new points, from which there is reason to hope that the present season will pass away without its becoming epidemic. Three or four cases have been reported in Louisville during the last month. At Chicago a few fatal cases have occurred. On the 9th of August it was announced that in St. Louis during the preceding week eighteen deaths had been produced by cholera and thirty by cholera morbus.

Our friend, Dr. Foss, has given us the history of some cases which, if not cholera, bore a striking resemblance to that disease. They occurred in his neighborhood, nine miles south of Louisville, toward the end of July and early in the present month. A mother and her two children—one aged five years, the other nine months—were attacked with purging and vomiting. The children died in about forty-eight hours; the mother recovered. On the 3d of August a German boy, aged eleven years, was attacked in a similar way. Dr. Foss found him with a cool skin of a bluish tint, very restless, and with great thirst. He died in fifty-six hours. The third night after his death his mother was seized with vomiting

and purging, but recovered. On the same night Mr. D., who had sat six hours with the corpse of the German boy, was attacked with the same disorder. Dr. Foss saw him next morning, and found him with a cool, bluish skin, face pinched, voice husky; pulse 60, feeble and intermittent; temperature  $96\frac{1}{2}^{\circ}$ . After passing rice-water forty-eight hours he recovered. Rice-water discharges attended all the cases, of which just one half terminated fatally.

The chief point of interest in the history of these cases is the character of the dwelling in which the subjects lived. "It is a flimsy two-story frame building," as Dr. Foss describes it, "with eight rooms, and stands on flat, badly-drained, stiff clay ground. It was occupied by three families and some hired hands, numbering in all about twenty tenants. Sixty feet south-east of the house is a stable accommodating eight or ten oxen, three horses, and three cows. The hog-and-cattle lot reached within ten feet of the dwelling. The entire drainage of this establishment passed under the shed-rooms at the north end of the house. This drain was obstructed in such a manner as to form a pool under these rooms, and a second one within four feet of the only door of the building."

The subjects of the first cases slept in the second floor of this shanty. The boy slept over one of the pools on the first floor, and after his death his mother occupied his bed. The average duration of the disease in all was three days.

The August number of the Nashville Journal of Medicine and Surgery contains a graphic and most interesting account of cholera, as it prevailed in that city this season, from the pen of its senior editor. Contrary to what has been stated, and to what we believed to be true, Dr. Bowling shows that the fatal epidemic was far from being confined to the creek and branch bottoms in the suburbs of the city; but that in the beginning at least all places alike were assailed, and that the greatest mortality occurred in a community of blacks on

a hill, "higher than the heights occupied by the reservoir or the state capitol." Dr. Bowling says that "it loved the high places and the clean places—clean because high—and did not flourish on runs or licks or branches." New Bethel, the community referred to, in which nearly half the population was carried off, is not only high but dry, "thoroughly drained, and with no branch or run in a mile of it." Here the "miserable population suffered ten times more than in any village of shanties in the low grounds." On Rolling-mill Hill, with no creek or branch within a mile of it, a mortality of twenty-three occurred, while in a very much larger population, on Lick Branch or Cockrill Creek, the mortality was only nineteen. A village at Fort Gillem, outside of the city, on a plateau as high as the water-works, lost seventeen, while only four died on Wilson's Spring Branch. Of the first seven cases six occurred on high ground, and the locality of the seventh was not low, and moreover was remote from any stream. Of the first seven negroes who died, six lived on elevated spots in various quarters of the city. On "black Friday," as it is styled by the people of Nashville, the 20th of June, the deaths from cholera amounted to seventy-two, of which forty-nine were among the blacks. The cases were distributed, Dr. Bowling shows, "over an area of three miles by four, an overwhelming majority occurring on high, well-drained land, and remote from creeks."

And so it was in former epidemics at Nashville, as Dr. B. relates. The top of College Hill was the first point assailed in 1850; the side of the hill sustaining the assault at a later day, and the inhabitants in the bottom remaining free from the pestilence, notwithstanding that their houses had been under water from a flood in the Cumberland a few weeks before. On that part of Lime Street which lies along the side of a hill not less than forty persons died of cholera, while on the section which extends into the valley not one died.

In a word, cholera avoided those localities at Nashville most subject to intermittent fever, and prevailed with signal mortality at points where intermittent fever is unknown. Nevertheless it may be doubted whether New Bethel, with its miserable colored population, "crowded into noisome shanties," should be called a "clean" place. It is in precisely such noisome places that cholera every where has exhibited its greatest malignity. And although in the beginning it seemed to attack all points alike, the "localizing causes" operated powerfully at last, and determined the frightful mortality of New Bethel and some other localities. The influence of local causes is conclusively shown by the fact that the number of blacks to the whites that died was nearly two to one.

It has been stated that cholera was imported into Nashville from Memphis or New Orleans. Dr. Bowling gives satisfactory reasons for doubting the truth of this statement; he assures us that no one came to Nashville from any place with cholera before the epidemic broke out, or during its progress. It may be alleged that persons from those cities brought the germs of the disease in their clothing, but the mode of its invasion is hardly consistent with the idea of its having been introduced by persons. Its progress was not successively from point to point, but "every ward in the city about the same time offered up one or more victims." "The disease," Dr. Bowling's remark is, "*fell* upon them." It was not preceded by the premonitory diarrhea which has been called cholérine; but broke out when high health was prevailing, at the close of the Exposition, and when the city was crowded with visitors.

We can not say that Dr. Bowling has made out his point respecting the connection between cholera and diet. A great many observations, a very long process of induction would be necessary to convince men that a disease which carries off its victims in a few hours can be induced by drinking a few

glasses of buttermilk, or by eating a few peanuts or an egg or two. Our learned friend of the Nashville Journal cites many instances of the sort by which his mind is thoroughly convinced. A professor, for example, he says, after escaping the disease long by dieting, "tried buttermilk, and it killed him." Mrs. L., being constipated, "stirred up two raw eggs in a pint of sweet milk and swallowed it, and slept that night in her grave." A woman ate some cabbage for dinner, and was in her grave that night. Another woman settled her coffee with the white of an egg, and fried and ate the yelk, from which she was near dying of cholera. A lady ate some raspberries with milk for dinner, and was dead before bedtime. "One of the most beautiful and accomplished young ladies in the city ate two or three pickles, and died." And after a few more instances like these, Dr. Bowling exclaims, "Let any medical-book-making or journalistic physician who advises fruit and vegetables in cholera times read these details and think!"

We have read them attentively, and have been thinking on the subject of diet in disease for a long time, but we confess that these details have not convinced us that cholera is ever caused by food. The result of all our observation and inquiry on the subject is a thorough conviction, on the contrary, that cholera needs no aid from food for its development, and that the diet which is most conducive to health in ordinary seasons is the safest and best diet in cholera times.

In regard to treatment, Dr. Bowling says nothing encouraging. Astringents, he declares, did no good, and opium did harm in the cases in which collapse supervened rapidly upon the purging and puking. Stimulants, given internally or applied to the surface, were equally unavailing to excite reaction. In the worst cases he prescribed "the *mistura rubra* of the London Hospital," with iced and saline lemonade, and crushed ice and ice-water *ad libitum*. He favored vomiting by the free use of ice-water. In addition, he gave to many

of his patients in collapse the sixth of a grain of calomel every half hour, and we infer from his remarks that some of them recovered. He publishes a note from Prof. Nichol, who says that in all the cases which came under his care he relied upon quinine and calomel. Prof. N. gave opium and its salts sparingly. He found quinine a liver medicine, and remarks that he has "seen the character of the discharges which we recognize as bilious follow the use of quinine as promptly as that of mercury." "The bad practice here," Dr. Bowling remarks, "consisted in a mad effort to stop the purging, and an unwise effort to stimulate the system into reaction."

Since the foregoing was written cholera has been announced at Lancaster, in this state, where twenty-two deaths from the disease had occurred in a week, but no new case was reported on the 24th. Nearly all the deaths were among the colored population.

"TO THE SURGEONS (FIELD AND HOSPITAL) OF THE ARMIES OF THE LATE CONFEDERATE STATES.—For the advancement of science—to rescue from oblivion all the important medical and surgical facts developed within the armies of the Confederate States during the late war—it has been determined to call a convention of the Confederate surgeons (field and hospital) to meet in Atlanta, Ga., May 20, 1874. Immediate action is considered absolutely necessary. Since the war many of the most talented of the medical staff have died, and yearly others are added to the list, their valuable medical and surgical experience entirely lost to the profession.

"For the success of this great scientific and historical association it is earnestly recommended that the ex-Confederate surgeons of each of the Southern States at once take such steps as will secure a large delegation. The co-operation of the medical staff of the late Confederate navy is respectfully solicited. Besides the contributions to science, the social features of this organization—the revival of old army associations—will be of no secondary interest. The railways of the South, with their usual courtesy, will no doubt grant excursion tickets for this most important occasion."



The above circular is signed by S. P. Moore, M. D., late Surgeon-general C. S. A., Frank Sorrel, M. D., Hunter McGuire, M. D., Frank Rice, M. D., Samuel Logan, M. D., John T. Darby, M. D., and twenty other well-known Confederate surgeons. It is accompanied by a letter from Dr. Edwin D. Newton, of Athens, Ga., who writes: "This call is based not alone upon the action of the Georgia Medical Association, but the earnest solicitations of many Confederate surgeons throughout the South as repeatedly expressed within the past two years."

We hardly need say that a movement which looks to bringing together the hundreds of strong and good men who gave luster to the medical service of the Confederate States army has our most cordial support. We believe it will meet a hearty response from Confederate surgeons all over the country. It is greatly to be regretted that some systematic effort to collect the professional experiences of the medical staff of the southern army had not been inaugurated soon after the close of the war. These experiences were fresher then, and there were more men to relate them; still it is not yet altogether too late to organize and begin the work. The surgeons who have taken the initiative in the matter deserve the thanks of their old comrades. Let us hope that the results of the movement will be such as to give additional honor to the name of "surgeon of the Confederate States army."

**EUCALYPTUS GLOBULUS IN MALARIAL FEVERS.**—As the season for marsh fevers is now at its height, the following note from Dr. F. B. Schulz, of Grand Tower, Ill., giving his experience in the use of the eucalyptus, will be of interest:

"I have now used the tincture of the eucalyptus globulus with well-marked success in thirteen cases of intermittent fever of the several types usually presented by that affection. In one accompanied by enlargement of the spleen, besides



giving the medicine internally, I applied it by means of cloths saturated with it directly over the enlarged organ. Whether this had any thing to do with the cure I am not prepared to say, but the ague-cake had disappeared at the end of a couple of months. Ferruginous tonics, purgatives, etc., were given conjointly with the eucalyptus, as I am in the habit of administering them when using quinia. The dose of the tincture, as given by Lorinser, in Vienna, is a dessert-spoonful, in water, taken four hours and again in two hours before the time of the expected paroxysm. In severe cases, or where the chill has returned, Dr. L. directs that the dose be increased a tea-spoonful. I use the following:

R. Tinct. of eucalyp. glob., . . .  $\bar{3}$ j;  
Syrup of raspberries, . . .  $\bar{3}$ ss;  
Water, . . . . .  $\bar{3}$ iv.

M. Dose, a table-spoonful every two hours during apyrexia.

Patients made no complaint of the taste of the mixture, and it gave rise to no disagreeable symptoms. I think finally that the disease yielded about as readily as it does to the sulphate of quinine and manifested no more tendency to return."

We should be glad to record the experience of other observers, not only with the eucalyptus globulus but also with cincho-quinine—a new product, which is very highly spoken of—in malarial affections.